AN INNOVATIVE CURRICULUM OF LITERATURE AND MEDICINE DURING RESIDENCY EDUCATION: POETRY ON THE WARDS

Pieter Aaron Cohen

Yale University

1998

AN INNOVATIVE CURRICULUM OF LITERATURE AND MEDICINE DURING RESIDENCY EDUCATION: POETRY ON THE WARDS

A Thesis Submitted to the
Yale University School of Medicine
in Partial Fulfillment of the Requirements for the
Degree of Doctor of Medicine

by
Pieter Aaron Cohen
1998

ABSTRACT

AN INNOVATIVE CURRICULUM OF LITERATURE AND MEDICINE DURING RESIDENCY EDUCATION: POETRY ON THE WARDS.

Pieter A. Cohen (Sponsored by Auguste Fortin).

Department of Internal Medicine, Yale University School of Medicine, New Haven, CT.

This study was designed to assess the introduction of an innovative, modular, case-based literature and medicine curriculum onto the wards during internal medicine residency education. Internal medicine teams from July to October of 1997 at two community teaching hospitals in Waterbury, Connecticut including seven attending physicians and 31 residents and students participated in twice weekly case-based poetry discussions. Attending physicians, residents and students were asked to complete anonymous questionnaires both prior to and following participation. Results were analyzed using two-tailed *t*-tests and chi-square analysis. Seventy-nine percent of the residents and students and 100% of the attending physicians found the written curriculum to be useful. Thirty-nine percent of the residents and students and 43% of attending physicians felt that the discussions had addressed specific clinical situations on the wards. After participating, the attending physicians agreed with the statement that time devoted to the humanities and medicine on the wards could improve house officers' abilities to talk to, understand and/or empathize with their patients (mean 3.7/5.0, SD 0.8). Qualitative data revealed that the discussions succeeded in introducing humanistic aspects of the practice of medicine during attending rounds. However, participants' attitudes toward time devoted to the humanities and medicine did not change significantly over the course of the intervention. The barriers identified by both attending physicians and residents to introducing the curriculum included lack of time, negative resident attitudes, and lack of perceived relevance to clinical practice. Solutions for overcoming the barriers include: (1) less frequent and more selective use of the curriculum in both the inpatient and outpatient settings; (2) further faculty development focused on teaching of the humanities in residency education; and (3) further research of residents' attitudes towards introducing the humanities and medicine during residency training.

ACKNOWLEDGEMENTS

I am indebted to Drs. Auguste Fortin, Asghar Rastegar and Catherine Viscoli for their dedication and commitment of time and finances for the curriculum and its evaluation; to Dr. Rafael Campo, Dr. Harold Horowitz, Dr. Majid Sadigh, Dr. Stephen Huot, Dr. Jeanette Ickovics, Leila Kern, Kirsty Johnston, Heather Lynch and Lauren Budding for their encouragement and support; to Eydie Sirica, Pauline DiNunzio and Tracy Redd for tactical support; and above all, to the attending physicians, residents and students who generously gave of their time, energy and enthusiasm.

TABLE OF CONTENTS

INTRODUCTION

The literary critic Anatole Broyard was diagnosed with metastatic prostate cancer in December of 1989. Broyard, before his death, reflected on the qualities of physicians,

> I would like a doctor who is not only a talented physician, but a bit of a metaphysician, too. Someone who can treat body and soul...I want a doctor with a sensibility...I wouldn't demand a lot of my doctor's time: I just wish he would *brood* on my situation for perhaps five minutes, that he would give me his whole mind just once, be *bonded* with me for a brief space, survey my soul as well as my flesh...Imagine having William Carlos Williams, who was a poet, or Walker Percy, who's a novelist, for your doctor...My ideal doctor would resemble Oliver Sacks. I can imagine Dr. Sacks *entering* my condition, looking around at it from the inside...He would look around, holding me by the hand,...then he would try to find certain advantages in the situation. Dr. Sacks would see the *genius* of my illness. He would mingle his daemon with mine. We would wrestle with my fate together.[1]

As Broyard emphasized, the spectacular success of scientific medicine in combating disease has not lessened the need for humanistic physicians who balance the technology of science with the attributes of a healer. How to describe, reinforce and teach these essential skills, sometimes referred to as the "art of medicine," has concerned educators throughout the century. Over seventy years ago, Francis Peabody wrote that, "one of the essential qualities of the clinician is interest in humanity." [2] Many disciplines have since tackled the daunting task of introducing and inculcating the human qualities of medicine into the education of physicians.[3]

These qualities—among them compassion, empathy, respect, insight, integrity—can be taught alongside the biological sciences. It may be possible from the study of the humanities and social sciences, specifically philosophy, ethics, religion, anthropology, history and the arts, to gain the humanistic skills to complement the technical expertise of the ideal physician.[4, 5] In a survey of about 1,000 physicians, 63% of responding physicians wished they had studied more of the humanities in college and a frequent reason sited was to enhance their ability to work with patients.[6] Many fields of knowledge contain potential for training the humanistic physician.

The poetry curriculum was designed to facilitate the incorporation of the physicians' humanistic skills into internal medicine residency education. Before describing the curriculum's implementation and evaluation, this introduction will provide the historical and intellectual backdrop for a literature and medicine curriculum that uses

discussions of poetry in a case-based manner on the wards. A brief history of the field of literature and medicine will be followed by the theoretical foundations for its application to the clinical practice of medicine. Literature and medicine curricula for medical students and residents will be reviewed as well as the available data on the curricula's impact. Barriers to the introduction of humanities into residency education will be reviewed. Throughout the introduction a special focus will be maintained on the use of poetry within literature and medicine.

I. Genesis of Literature and Medicine as a Field of Study

The roots of the modern field of literature and medicine lie, in part, in physicians' centuries-old use of literature for the teaching of medicine. In the eighteenth century, as a physician at the vanguard of medicine, Thomas Sydenham played an integral role in conceptualizing diseases and syndromes as generalizable entities. In 1723 when asked by a student what books one should read to qualify him for practice, Sydenham replied without qualification, "Read *Don Quixote*, it is a very good book. I read it still."[7] The interests of physicians who turned to writing as a literary pursuit and of literary critics who studied medical topics in literature also helped establish the new field.

Although physicians and literary critics have engaged in these pursuits for years, it was not until the early 1970s that the first literary scholar, Joanne Trautmann Banks, was hired by an American medical school to teach literature to medical students.[8] She organized the first symposium on literature and medicine in 1975[9] and authored the earliest publications in this field.[10] During her tenure the concept of literature and medicine expanded from the representation of medicine, physicians and patients in literature[8] to a broader appreciation of literary constructs and theory in the study and practice of clinical medicine.[11] The journal Literature and Medicine dedicated to the field was established in 1982[12] and professional societies, graduate school programs and federally funded training programs soon followed.[11] By the early 1990s, with several medical-humanities faculty positions in the United States dedicated to literature, the field had come into its own.[8]

II. The Theoretical Foundation for the Application of Literature and Medicine

The study of literature and medicine grew as its potential to impart clinically relevant skills, attitudes and knowledge was appreciated.[11, 13, 14] This potential may be conceptualized as follows: (1) the application of literature's ability to realistically reflect illness, suffering, and death (literature as mirror); (2) the study of literary analytic skills and theory and their application to the practice of clinical medicine (literary skills); and (3) the appreciation of literary forms of knowledge which may inform the clinical practice of medicine (literary knowledge).[†] Although these categories are useful concepts, they represent a continuum in the study of literature and medicine that contribute to the physician's and student's professional development. For clarity in the following discussion, the theoretical uses of literature in medicine will be discussed using this conceptual basis.

A. Literature as mirror

Physicians can utilize the ability of literature to create rich and complex accounts of human suffering, illness and death.[15, 16] Literary scholar Anne Hudson Jones traces to antiquity this concept of literature as mirror.[17] Fictional 'cases', such as that of Ivan Ilych in *The Death of Ivan Ilych*, may be as informative as an actual medical case presentation to the discussion of terminal care, moral decision making, quality of life, and physicians' role in care giving.[11] Scholars have argued that the reality of literature at times exceeds the understanding one can gain from scientific truth.[15] Literary accounts of illnesses have served as foundations for discussions of medical ethics,[18, 19] the doctor-patient relationship,[20, 21] death and dying,[22, 23] and the illness experience[24] among other topics.[11, 13, 25, 26]

The study of life through literature exercises the imagination, engages the emotions, and has the potential to teach compassion and empathy.[15, 27] Through the complex characters in literature, readers are introduced to people who, at times, evoke

[†] In addition to the skills, attitudes and knowledge gained from the study of literature, students and physicians can gain the personal and professional enrichment and satisfaction which comes with appreciation of the arts.[3, 15]

multiple, ambiguous and uncertain emotional responses. Literary characters may simultaneously evoke admiration and disdain, respect and discomfort. Accepting this ambiguity and recognizing one's emotional responses may facilitate physicians' capacity to nurture relationships with patients who at first may be considered 'difficult' or 'problem patients'.[28, 29]

Literature also provides the opportunity to reflect on the role of physicians within society and culture.[11, 30] Works such as Thomas Mann's *The Magic Mountain* and Albert Camus' *The Plague* allow physicians and students to consider the practice of medicine within different historical and social contexts.[31, 32] Physicians are then able to reflect on their professional decisions recognizing how they are shaped by their own cultural context.[11] For example, the physician Robert Coles[18, 33] and others[34] have stimulated their students' moral reflection through the study of literature. Therefore, as a nuanced reflection of life, literature may provide insight into illness experiences, enhance empathy, stimulate moral reflection and provide cultural context.

B. Literary skills

The analytic study of literature can offer the physician skills from literary criticism and theory that may be directly or indirectly useful in the practice of medicine.[11, 35-37] These skills may roughly be categorized into two areas: 'basic' skills of literary analysis and narrative theory including narrative ethics.

The 'basic' literary skills focus the reader's attention on language, word choice, context, metaphor, and the power of language. Honed through the reading and analysis of literature, these skills are directly applicable to clinical medicine because they are the basic skills of communication. Nowhere are these skills more important than in the doctor-patient relationship. The physician's clinical acumen requires careful and attentive use and interpretation of language. Patients also rely on symbolic language, metaphor and careful word choice to communicate with their physicians[38] and it is the interpretation of these expressions that form the foundation of the clinical encounter. The physician's choice of language in their relationship with their patients may have power in its own right.[39] Finally, other literary skills, such as applying formal traditions of

criticism to help form and refine hypotheses, may be useful when teaching diagnosis to physicians in training.[35, 36, 40-42]

Narrative theory is a literary technique that may be useful to clinicians.[43] The narrative concept of literature reminds us that, not only do all humans conceptualize and articulate their life experiences in the framework of a narrative or story, but that this story is shaped by both the author and the reader. As Howard Brody has eloquently argued, narrative structure emphasizes the need to understand a patient's personal story before the physician can appropriately interpret and, often, treat a patient's illness.[44] Taking a broader view, Arthur Kleinman has argued for narrative's ability to place a patients' illness within the appropriate social and cultural setting.[45] Narrative theory has also focused attention on the dialogue between patient and physician in comprehending illness and therapy.[46] In addition, medical knowledge, in clinical histories and case reports, is itself often based on, and transmitted by, narrative.[47] Narrative knowledge has been described by Rita Charon as a "road to empathy".[28] The use of narrative theory in medical ethics has been described by Brody,[44] Charon[48] and others,[46, 49, 50] and has become a 'subspecialty' of literary and ethical study termed 'narrative ethics'.[37] Understanding the importance of narrative has the potential to enhance medical knowledge, clarify ethical decision making, elucidate cultural context, and strengthen empathic qualities.

C. Literary knowledge

The literary concept of epiphany, originating in James Joyce's writings, describes an intuitive grasp of reality through a simple and striking event. Joyce juxtaposed commonplace objects and events and was able to create experiences, thoughts or sensations which transcended the everyday.[51] Although epiphanies cannot be quantified, the potential of knowledge acquired in this form should not be overlooked in the practice of medicine.[52] As Anne Hudson Hawkins has argued, the integration of knowledge gained by epiphany may enhance the logical deductive reasoning of the biomedical approach.[14] Literature might be able to heighten the physician's appreciation and increase his or her receptivity to these moments of insight. Also by juxtaposing literature and medical care, the setting may be conducive to insights into clinical reality. The concept

of epiphany and medicine will be expanded upon in the following section on poetry and medicine.

III. Poetry within Literature and Medicine

Poetry and medicine have intersected since ancient times when Apollo was considered the god of healing, song and poetry.[27] Today physicians' poems grace the pages of the *Annals of Internal Medicine*, *The Lancet* and *JAMA* on a regular basis reflecting the importance of communicating through the arts as well as science. Physicians have occasionally gained wide reknown as poets. One of the most well respected American poets, Williams Carlos Williams (1883-1963) was also a lifetime practitioner of medicine in rural New Jersey. Contemporary American physicians, such as Rafael Campo and John Stone, are both poets and physicians.[53, 54] A traditional avenue of scholarly interest has been the life and work of physician-poets,[55-60] where the debate often centers on the relationship between the physician's clinical practice and their poetry.[18, 59] Although interesting, these discussions are outside the scope of this paper which focuses on the potential uses of poetry in medical education.[†]

Poetry has been of interest to physicians, patients, and students for years but, like other forms of literature, was not considered as a tangible adjunct to the training of physicians until the 1970s. Although some scholars, such as Kathryn Montgomery Hunter, incorporated poetry into their teaching in literature and medicine from the beginning, poetry has more commonly been overshadowed by novels, short stories and drama in the literature and medicine curriculum.[60] Despite the less frequent use of poetry, most teachers in the humanities and medicine have incorporated some poetry into their curricula and ascribe to it the same benefits and qualities as those of novels and short stories.[11]

Similar to the arguments made for introducing novels, short stories, and drama into medical school and residency curricula, poetry has been regarded as having the ability to nurture physicians' humanistic qualities and capacity for empathy.[14, 17, 27, 62, 63]

[†] For more information, the reader may consult Anne Hudson Jones' excellent, recent overview of physician-poets.[61]

Poetry, along with the other fields of literature, has been heralded for its mimetic ability to create a rich, nuanced context in which medical and nonmedical events can unfold to a "case" from which discussions of the ethical and other nonscientific dimensions of clinical practice can emerge.[33, 60, 63, 64] Scholars have argued that the literary techniques used to critique poetry parallel the skills of medical diagnosis and are therefore productively taught together.[36] Others have maintained that the literary skills that are strengthened by the reading and interpretation of poetry are particularly useful for physicians because of their contrast to day-to-day practice of medicine.[65]

While some scholars have advocated for the use of poetry to nurture empathy, to stimulate ethical discussion, and to apply literary skills to the practice of medicine, others have focused more specifically on the unique qualities of poetry. Often, poetry is succinct and complex. The brevity of poetry has been seen as a major strength for its introduction into the education of busy physicians.[35, 62] In addition, readers are challenged and stimulated by poetry's complexity.[35] However, poetry's complexity may deter students and residents if they do not feel skilled in reading, appreciating and interpreting poetry.

As mentioned above, another important strength of literature, especially poetry, is its ability to nurture the knowledge gained from epiphany. Anne Hudson Hawkins argues that of all the literary forms, poetry has the greatest ability to develop "epiphanic knowledge".[14] She acknowledges that the reader is often incapable of expressing this knowledge in words, unless he or she happens to be a poet. And she emphasizes that epiphanic knowledge is not sufficient by itself to guide decision making, but combined with deductive reasoning, enhances the physician's clinical skills.[14] Hawkins refers to the understanding of epiphany within the context of ethical decision making, but her theory is generalizable to many other situations in medicine including death and dying, intractable pain, and refusal of medical care. Anne Hudson Jones describes Hawkins' insight gained from poetry as a lamp ignited by epiphany which illuminates the human context of the ethical or medical dilemma.[17]

Poetry heals. This is the final and most controversial of all claims about poetry and medicine. This claim, however, is made from many different perspectives and bears

consideration. Because of its ability to stimulate reflection and enhance professional satisfaction, poetry has been described by literary scholars as a healing force in the lives of physicians.[60, 66] Others have argued that while medicine addresses suffering of the body, poetry addresses suffering of the spirit.[27, 61, 67-69] The field of cross-cultural studies has recognized poetry's ability to heal through the study of Navajo and Iroqois oral traditions which use lyric poetry to restore individuals to health.[70] When the question was posed to the readers of the *British Medical Journal*,[71] respondents' noted reduced stress and increased mood as benefits of poetry.[68]

Physicians who write poetry are particularly eloquent, and often adamant, when discussing the power of language and poetry to heal. William Carlos Williams believed that "we[, physicians,] have to pay the closest attention to what we say. What patients say tells us what to think about what hurts them; and what we say tells us what is happening to us—what we are thinking, and what might be wrong with us."[18]

Contemporary physician-poets agree.[67, 69, 72] Cardiologist and poet, John Stone at Emory School of Medicine argues that,

> Writing poetry has made me a better physician, and I find no conflict between them. It is one way of making sense out of the world, and...it has the power to heal. Medicine is a losing game, but inherent in poetry is magic and an affirmation of life. Some scientists call the arts 'soft data,' but in reality they are the hard data by which we live our lives.[69]

Rafael Campo, an internist and poet, at Beth Israel Deaconess Medical Center eloquently echoes this sentiment,

> I wonder, then, whether poetry might also be therapeutic...If poetry is made of breath, or the beating heart, then surely it is not unreasonable to think it might reach those places in the bodies of its audience, however rarefied...Poetry is a pulsing, organized imagining of what once was, or is to be. What life once was, what life is to be. It is ampules of the purest, clearest drug of all, the essence and distillation of the process of living itself.[67]

Physician-poets are not the only ones to champion poetry and its healing powers. Literary critics, poets and popular authors also describe the power of poetry and language in their ability to heal and to harm. The literary critic Anatole Broyard wrote,

> I don't see any reason why doctors shouldn't read a little poetry as part of their training. Dying or illness is a kind of poetry. It's a derangement...So it seems to me doctors could study poetry to understand these dissociations, these derangements, and it would be a more total embracing of the patient's condition.[1]

The poet Denise Levertov, when asked of the poem's usefulness to the practicing physician wrote,

> ...poetry can have, for those whose attention is apt to be intensely focused on a narrow or discrete area, a special usefulness, stimulating the imagination as it does, revealing analogies, and, by its concrete, sensuous, image-rooted vocabulary, redirecting the sensibility to the underlying dynamics of language.[73]

In the popular press, many authors have explored the power of language in the doctor-patient interaction. Norman Cousins in *The Healing Heart* writes of the power of language, "the right words can potentiate a patient, mobilize the will to live...The wrong words can produce despair and defeat or hinder the usefulness of whatever treatment is prescribed."[74] All of these comments return to the usefulness of studying language, images, and poetry.

IV. Specific Literature and Medicine Curricula

The burgeoning of the field of literature and medicine over the last twenty years has been accompanied by an increase in the perceived utility of literature in the clinical practice of medicine. These changes have lead to a parallel growth in literature and medicine curricula at medical schools throughout the United States. Prior to the 1970s humanities would have been, at most, an interesting aside to a medical school's curriculum. However, by the 1970s courses were being designed for medical students in which literature became a vehicle to address medical topics. These curricula appeared independently at various medical schools in the United States and abroad, including Pennsylvania State University,[10] Harvard University[64, 75] and the University of Melbourne[19, 76] among others.[77-79]

A. Medical student curricula: preclinical years

According to one informal survey, by the mid-1990s approximately one-third of medical schools offered a required or elective course in the humanities and medicine.[11] These courses are offered most commonly during the preclinical years[13] in a variety of formats using techniques reflecting instructors' varied interests and strengths. One month-long course combines instruction in clinical history taking with readings about

illnesses.[75] More traditionally structured elective and selective courses use literature, film and/or art to focus discussions on medical themes.[24, 80-83] Another approach is a two-week long immersion into short stories and poetry for first-year medical students.[78] Other workshops encourage medical students to write from their patient's point-of-view, creating a patient-centered narrative.[13, 84] Some curricula integrate the arts, including literature, into the first year anatomy experience,[77, 85, 86] while some offer the opportunity for students to write essays about their anatomy experience or write the narrative story of their first 'patient', the anatomy cadaver.[13, 77, 87, 88] The great majority of literature used during the preclinical years is incorporated into classes which teach interviewing skills, or focus on the topics of the doctor-patient relationship, ethics, history of medicine and related aspects of the medical curriculum.[13, 20, 23, 79, 89, 90]

B. Medical student curricula: clinical years

Published examples of courses, workshops or small group discussions utilizing literature and medicine during the clinical years of medical school are less common. Surgery faculty have used excerpts from classic writings in literature and medicine to stimulate discussions of medical ethics.[19, 25, 76] Students entering pediatric clerkships have been taught deductive reasoning through Arthur Conan Doyle's mysteries.[40] A fourth-year selective course at SUNY Stony Brook focuses attention on specific medical themes through readings of literature.[89] Other elective courses create reading groups of faculty and students.[91] In some instances, third year students have been encouraged to write from the perspective of their patients.[92, 93] Fourth year students may attend a class on Literature and Medicine at East Carolina University School of Medicine.[90] At the University of North Carolina at Chapel Hill School of Medicine, literary study is incorporated into integrated fourth year medical humanities courses.[13] Other medical schools, such as Yale School of Medicine, offer optional literary readings and group discussions to complement components of an integrated clinical medicine course in the fourth year.[94] Given the popularity of these courses, workshops, and small group discussions during the clinical years of medical school it is not surprising that there has also been a call for the teaching of literature and medicine during postgraduate training.[95-99]

C. Residency curricula

The study of literature and medicine may also benefit physicians who are actively caring for patients. Many have called for the incorporation of literature into residency training in surgery,[95] family practice,[99] pediatrics[98] and internal medicine.[96, 97] Forty years ago, William Carlos Williams agreed, "My friends tell me that they wish some of my stories and poems were read by medical students, and I've never argued with them on that score—but the later, the better...If the reader were a doctor—then so much the better!"[97] However, few formal opportunities have been created for residents to study literature and medicine.

Similar to the curricula introducing literature into medical school education, residency programs have approached the introduction of the humanities in many different ways. Some programs organize evenings which combine dinner and discussions of the humanities with an opportunity for residents and attending physicians to interact socially. For example, Yale's Internal Medicine Primary Care Residency Program offers quarterly 'arts and medicine evenings' at which both faculty and house staff meet in a setting outside of the hospital to hear a presentation and discuss literature, drama, music or art.[100] At the Raritan Bay Medical Center in New Jersey, internal medicine residents are assigned readings and attend a series of required evening humanities conferences.[101] Voluntary and elective reading groups have also been used to incorporate literature into medical residency education.[96, 102] A unique clinical rotation at the Medical University of Southern Carolina teaches family practice residents to care for dying patients by combining clinical care with seminars utilizing novels, drama and film.[22] Literary scholars have explored the benefits of having residents write accounts from their patients' perspectives.[103] Physicians, who appreciate the benefits of combining literature with clinical medicine, incorporate literature into presentations and discussions from grand rounds[104] to attending rounds.[11, 62, 82, 105]

D. Poetry within literature and medicine curricula

A review of the literature reveals that many literature and medicine curricula for medical students, although rarely focusing on poetry, usually include poems.[19, 24, 78, 89, 91, 106] However, poetry has often taken a back seat to other forms of literature and received "surprisingly little attention".[8] A survey at a meeting in the mid-1980s of educators in the humanities and medicine revealed an enthusiastic use of fiction, followed by drama and autobiography but few scholars reported teaching poetry.[60]

There have been a few medical school courses that focus on poetry. The poet and cardiologist John Stone has led a workshop in which he encourages medical students to write poetry.[61] In a similar vein, a contest has been established for poetry written by medical students,[107] and the Department of History of Health Sciences at University of California, San Francisco has offered an elective "Poetry in Medicine".[108]

Poetry has been used at grand rounds to help facilitate discussion of the doctor-patient relationship.[104] Poems have appeared in medical articles on ethics[109] and AIDS[110] and even in patients' charts.[28] Medical articles occasionally address poetry for its own merits, for example *Academic Medicine*'s 'Medicine and the arts'[111] and *The Lancet*'s 'Literature and medicine'[63] sections.

Poignant anecdotal accounts of the use of poetry during residency are sprinkled throughout the literature. An internal medicine resident returned to his former teacher in literature and medicine, Robert Coles, and described the following,

> A patient of mine was reading Robert Frost. One morning he asked me what I thought Robert Frost was reading when he lay dying...I'll be walking down one of the corridors...and the lines from 'A Death Place' [a poem of dying] will come to me again. I'll begin to think I'm crazy, hearing the words over and over...I've been living out the doctor's side of that poem, seeing people who are staring at death. I've wished I could share some poems with those patients....[64]

Raphael Campo, the internist and poet, does recall sharing a poem with a patient on the wards as a resident at San Francisco General Hospital,

> Late at night, after restarting an IV or evaluating a new fever, I lingered in a patient's room to talk. Or, in one particular case, to read Thom Gunn's poetry aloud—when we heard the respirator functioning in the plunging up-and-down iambics of "Lament," we nearly cried together.[67]

These anecdotal accounts hint at the potential usefulness of poetry for medical residents and their patients, but very little has been published by those who have attempted to introduce poetry directly onto the wards. There are unpublished accounts of attending physicians using poetry in the training of residents in programs as diverse as a psychiatry residency in Ohio to internal medicine training in India. [112] However, an extensive literature review reveals only one published account of introducing poetry in an organized fashion into ward rounds.

Harold Horowitz at Westchester County Medical Center, New York, set aside one third of daily rounds to discuss poetry with his team of residents and medical students. He encouraged each member of the team to bring in poetry, preferably from their country of origin. Discussions ranged from residents' feelings of loneliness at the hospital to withdrawal of medical care at the end of life to the demands placed on physicians' personal relationships. Horowitz' goal was "to address aspects of medical care parallel to, but not specifically about, medical diagnosis and treatment".[62] He hoped that he would in turn 'humanize' rounds and thereby train more caring physicians. Horowitz also hoped that these moments of reflection might help alleviate the 'burnout' of overworked residents.

VI. Impact of Literature and Medicine Curricula

Despite the many innovative literature and medicine programs in both medical school and residency programs, there is a paucity of information regarding their impact. Published data has consisted of questionnaires and, less frequently, one-to-one interviews that focus on participants' general satisfaction. The data are generally favorable. Results of questionnaires from medical students in their preclinical[20, 23, 24, 75, 77, 78] and clinical years[19, 84, 91] as well as from internal medicine residents,[62, 96, 101, 113] have been published. The results are commonly reported in general terms such as "course evaluations were extremely positive,"[81, 84] or sample responses are given.[62] There have been few attempts to measure the impact of curricula using quantitative measures.[19, 75, 77, 78, 91] To my knowledge, there are only two published attempts to measure attitude change by looking at pre- and post-intervention questionnaires.[20, 86]

A. Medical students' responses

A review of the quantitative data from literature and medicine curricula is instructive. Data are available from three elective courses for preclinical medical students.[75, 77, 78] Preclinical Harvard medical students attending an integrated seminar combining literature, patient interviews and house calls rated the content and relevance of the seminar to clinical medicine as excellent on a five-point scale.[75] At Wright State University School of Medicine in Ohio literature and medicine was used to introduce preclinical students to humanistic qualities of medicine[78] and to the initial cadaver dissection.[77] Preclinical students rated the first course as achieving its objectives (4.6/5.0) and relevant to the future practice of medicine (4.3/5.0).[78] However, in the humanities course integrated into anatomy, the same students rated a writing assignment about the cadaver and readings about the experience unfavorably (2.7/5.0 and 2.9/5.0, respectively).[77] The students' considerable resistance led to the discontinuation of the literary and writing portions of the anatomy-related course.[77] On the other hand, a similar integrated course for first year students studying anatomy at the University of Massachusetts Medical School received extremely positive responses. The students particularly enjoyed the literature and art which were discussed as part of the course.[23]

Hunter and Axelsen evaluated a two-year integrated course on human values at Morehouse School of Medicine by having students complete a questionnaire that evaluated 'authoritarianism'.[20] Their students' mean 'authoritarian' scores decreased over the two-year period, but given the small sample size of 20 students, these changes were not statistically significant. Terry used pre- and post-intervention questionnaires with medical students selected to attend a series of humanities classes complementing anatomy class as well as to a control group that did not attend.[86] Terry found no statistically significant changes or differences in the responses of his two student groups to questions regarding their perceptions of their cadaver, their interest in addressing the emotional aspects of dissection, and their wishes regarding the donation of their own bodies for dissection.[86]

Medical students on their surgical clerkship at the University of Melbourne, Australia, attended a required seminar in which extracts from literary works were used to

address clinical ethics.[19] The author found that 96% of the 79 students felt that the seminar dealt with original areas of medicine, 83% of attendants felt that they were challenged to think and articulate their opinions on previously unconsidered topics, and 90% of respondents stated that the discussions called to mind specific cases on the wards. In an offering at the University of Glasgow, UK, clinical medical students attended an elective course in literature and medicine over four evenings.[91] Eighty percent of the 25 students felt that the course had met its goals of introducing them to literature, broadening their perspectives, and encouraging them to reflect on and consider the views of others.

To the best of my knowledge, there is no published quantitative data from residents exposed to curricula in literature and medicine. Nor is there any available quantitated data concerning the impact of curricula that focus predominantly on poetry. In Horowitz' poetry 'experiment', described above, a survey was distributed to his residents in which the majority of respondents considered the discussions 'excellent' or 'good'. Horowitz believed that "the poetry discussion facilitated better interpersonal relationships among team members."[62]

B. Program directors' responses

Faculty views of literature and medicine curricula have been surveyed. In 1983 Povar and Keith analyzed responses from 102 program directors of internal medicine residency programs who assessed their program's use of the humanities.[114] Although a fifth of the programs incorporated 1 to 36 hours of literature and medicine into their curriculum, Povar and Keith found that program directors on average rated literature and medicine as a 'nice' pursuit which was 'interesting but should not take curriculum time from other areas'. When asked to categorize the perceived interest of the residents in various topics on a scale from 'very receptive' to 'uninterested', the directors believed that their residents were 'neutral' to literature and medicine.

VII. Barriers to the introduction of humanities and medicine into residency training

Povar and Keith asked internal medicine program directors to identify problems that they had encountered in integrating the humanities into their curriculum.[114] The

majority of respondents identified the 'lack of time' both of residents and faculty as the most common obstacle. Other frequently described barriers were lack of residents' interest and lack of qualified teachers and/or curriculum planners. More recently Strong et al. surveyed faculty members regarding the perceived difficulties of teaching ethics in residency.[115] Similarly, time constraints, resident attitudes, logistical problems, and lack of reinforcement were the major impediments to teaching ethics in residency programs.[115] The ethicist David Barnard has pointed to the "pace and structure of residency education" as a major difficulty to introducing the humanities and medicine into residency curricula.[113]

Little data has been quantified regarding residents' attitudes toward the introduction of humanities and medicine curricula. However, the available evidence suggests that residents are similarly concerned with lack of time as well as the curriculum's relevance to the practice of clinical medicine. [96]

STATEMENT OF PURPOSE

As reviewed above, there have been few published accounts of literature and medicine curricula introduced into internal medicine residency programs. These curricula for internal medicine residents have included evening lectures and discussions[101] as well as elective[96] and required[102] reading groups. The settings of these activities in faculty homes and other venues outside of the medical environment have been described as creating a unique and important atmosphere to explore complex and personally challenging topics.[113] I propose that there exists untapped potential to utilize literature and medicine as part of residency education situated directly in the clinical setting.

I set out to design, implement and assess a curriculum which would allow attending physicians and residents without prior experience to use poetry to illuminate and facilitate discussion of specific clinical situations on the wards, particularly those that are considered difficult to discuss using the 'medical literature'. Death and dying, angry patients and chronic pain are often difficult or uncomfortable to address on the wards. The poetry curriculum was designed to focus attention and facilitate discussion of these clinical problems as they occurred on the wards.

Although often neglected in busy clinical settings, the humanistic aspects of the practice of medicine are essential to the development and education of a mature physician. The primary objective of the poetry curriculum was to begin to compensate for this deficit in residency education. A secondary objective of bringing literature into residency education was to develop literary skills, expand knowledge and foster attitudes essential to the practice of clinical medicine. The curriculum was designed to complement, rather than replace, established literature and medicine curricula based outside of the hospital setting and other forms of the humanities such as ethics which have been successfully incorporated into the medical setting.

In addition to satisfying these needs, the curriculum was also designed to overcome the barriers to the introduction of humanities into residency education. Given the available data, the major barriers were presumed to be lack of time, lack of resident interest, and lack of attending physician expertise.[114, 115] Pre- and post-intervention questionnaires were used to determine whether these barriers existed in the study population and whether they were overcome by the curriculum.

METHODS

Study participants: All 11 full-time and part-time faculty who were scheduled to be ward attending physicians on internal medicine teaching teams at two community hospitals (St. Mary's Hospital and Waterbury Hospital both in Waterbury, Connecticut) from July 25 to October 23, 1997 were invited to take part in the 'poetry on the wards' curriculum. Seven of the 11 eligible attending physicians chose to participate in the study. These seven had 26 residents and five medical students assigned to their teams during the three month intervention. These residents, interns and medical students formed the intervention group. The project was approved by the Institutional Review Board at Yale School of Medicine.

Poetry curriculum: The poetry curriculum included the following materials:

1. Remarks that attending physicians could use to introduce the project to their house officers.
2. A series of seven bound packets designed to be used when caring for 1) dying patients; 2) patients who engender anger or disgust; 3) patients with intractable pain; 4) patients who refuse medical therapy; 5) patients adjusting to illness and the hospital setting; 6) patients with AIDS; and 7) patients with addictions. See Appendix A for poetry included in each packet. Each of the seven packets included the following:

a) An introduction to reading and presenting poetry for residents. See appendix H.

b) Three or four selected poems, each with introductory notes.

c) A bibliographic guide to American poetry and medicine. See appendix B.

The author collected the poetry from published curricula of medical humanities courses, poems published in medical journals, anthologies of poetry relevant to medicine, suggestions from graduate students of Yale University's English Department, and suggestions from colleagues. The following criteria were used to select the poems: 1) English-language, mainly American poetry written in the 20th century (exceptions, Dylan Thomas [Welsh] and Emily Dickinson [19th century]); 2) topic, subject, situation or theme directly or indirectly relevant to one of the seven packets; 3) poem short enough to be read and discussed during the allotted time; and 4) range in difficulty within each packet from straightforward to complex. Each poem was accompanied by brief biographical data about the poet and suggested questions for use during the discussion.

Procedure: Eligible faculty were invited to a one-hour faculty development workshop prior to the intervention. Pre-intervention questionnaires were distributed and completed. The purpose, goals and design of the intervention were presented followed by a fifteen minute role play of the poetry discussion. The attending physicians had an opportunity to participate in the role play, ask questions and voice concerns.

Prior to the start of the intervention, each attending physician received the following materials:

1. An introduction including the purpose, goals and design of the intervention.
2. Pre-intervention questionnaires for residents to be distributed at the team's first attending rounds. See Appendix D.
3. Two copies of each of the seven packets.
4. Post-intervention residents' questionnaires to be distributed at the end of the month.
5. A bright orange pocket reminder of the above responsibilities and the author's phone and beeper numbers to be contacted as questions arose.

At these hospitals, interns and residents rotations are staggered by one week so that there is a three-week period during which the team is complete. During each of these three weeks, the attending physicians were asked to identify two patients who fell into one of the seven categories described above (e.g. a patient on the wards with intractable pain). For each patient identified, the attending physician was asked to give the relevant packet (e.g. the "intractable pain" packet) to the intern or resident caring for that patient. The house officer was responsible for presenting one poem during attending rounds that week. That house officer chose one of the poems in the packet or brought in a poem of his or her own selection. The attending physician was instructed to set aside fifteen minutes of attending rounds for the house officer's presentation and the team's discussion of the poem. The resident was asked to provide copies of the poem to each member of

the team and begin the presentation by reading the poem aloud. The house officer was able to choose any format or style in which to present and lead the discussion of the selected poem. Attending physicians were asked to facilitate two discussions a week, for a total of six discussions per month. This schedule was repeated for three months.

After the last poetry discussion of the ward month, post-intervention questionnaires were distributed to attending physicians and residents. If an attending physician, resident or student's post-intervention questionnaire had not been received within four weeks after the end of the assigned time period, the author contacted each individual by phone and mailed or faxed a second copy of the questionnaire to him or her. If the second questionnaire was not received, a third attempt was made to contact the individual either by pager, mail or fax.

Attending physicians who had informed the author that they did not wish to participate, did not distribute questionnaires to their team, or did not organize any discussions of poetry during attending rounds were interviewed by telephone to ascertain their reasons for not participating.

Instruments:

- The *pre-intervention* questionnaire (see Appendix D) for the *residents and students*

  A. Assessed baseline characteristics:

     1. sex, age, residency program (primary care, traditional internal medicine, transitional year) and year, native language, and country of prior medical training

2. amount of time spent reading medical and nonmedical literature
3. prior experiences in the humanities and medicine[†]

B. Measured attitudes and 'medical empathy' that might be affected by the intervention:

1. interest in learning about the humanities and medicine
2. perceived utility of time spent with humanities and medicine in various medical settings
3. questions to evaluate physician empathy using the Medical Empathy Scale (MES) (The MES had been previously developed, piloted and validated at the University of California at Los Angeles internal medicine residency program.[116] (See Appendix C for scale.)

- The *post-intervention* questionnaire repeated B above. This questionnaire also asked for a qualitative evaluation of the poetry intervention. (See Appendix E.)

- The *pre-intervention* questionnaire for the *attending physicians* assessed the following areas (see Appendix F):[*]

1. prior experiences with the humanities and medicine
2. interest in teaching the humanities and medicine
3. comfort and perceived expertise in teaching the humanities and medicine

---

[†]For the purposes of this survey the term 'humanities and medicine' was defined as *either* the field which incorporates both the study of the humanities (e.g. literature, art, film, drama, and music) along with the study of medicine *or* any activity that incorporates the humanities in the practice of medicine.

[*] Demographic information of all eligible attending physicians was gathered directly from their respective Departments of Internal Medicine.

4. perceived utility of time spent with the humanities and medicine in various medical settings

- The *post-intervention* questionnaire for the attending physicians repeated areas 2 through 4 above and asked for a qualitative evaluation of the poetry intervention. (See Appendix G.)

Statistical analysis: The distribution of baseline characteristics of residents, students and attending physicians was examined. Two-tailed T-tests were used to examine changes in attitudes and 'medical empathy' pre- and post-intervention. Chi-square analyses were used to evaluate relationship between baseline resident and student characteristics and change in attitudes defined as increased interest, decreased interest, and no change in interest. Chi-square analyses were used to evaluate the relationship between change in resident attitudes and their attending physician's baseline characteristics.

RESULTS

Response Rate and Exposure

Pre-intervention questionnaires were received from 94% of the residents and students. Post-intervention questionnaires were received from 90% providing 26 matches (84%), 22 residents and four medical students. Pre-intervention questionnaires were received from 10 of the 11 eligible attending physicians (91%). Post-intervention questionnaires were collected from all seven (100%) of the participating attending physicians.

Five of the eleven eligible attending physicians participated in the optional one-hour faculty development session prior to the intervention. Of the seven participating attending physicians, four (57%) had attended the faculty development session.

The residents and students reported participating in poetry discussions a mean of 3.3 times (SD 1.7). Each resident and student led the discussions a mean of 1.4 times (SD 0.5). The attending physicians were present for a mean of 4.4 discussions (SD 1.5).

One attending physician was scheduled to attend for two months during the three month intervention. He chose not to participate either month. The residents and students were exposed for a one month period, except for one student who was assigned to three participating attending physicians during the intervention.

Residents and Students

- **Baseline characteristics**

The participating teams consisted of five senior residents, seven junior residents, 12 interns and five medical students. There were 21 primary care residents and three traditional residents. The residents and student were 68% female (18/29) and 38% male (11/29). Their mean age was 30.9 years (SD 5.4, range 25 to 47). Their native language was primarily English (76%) followed by Spanish (7%) and one each of the following: German, Chinese, Urdu, and Bosnian. Eighty three percent (24/29) graduated from United States medical schools and 17% (5/29) trained abroad.

During their undergraduate studies, seventy-six percent of respondents had attended literature classes and 52% art classes, while fewer had studied music (38%), poetry (35%), drama/theater (28%) and film (28%). Fourteen percent of the residents and students had not studied either literature, music, drama or film as an undergraduate.

- **Medical and nonmedical reading**

Residents and students reported reading medical journals and texts for a mean of 6.7 hours a week (SD 4.3, range 0 to 20). They reported reading non-medical material (excluding magazines and newspapers) an average of 1.9 hours a week (SD 2.4, range 0 to 10). Many residents and students reported reading novels (52%) and non-fiction (41%), while a smaller percentage read poetry (17%) and drama (3%) on a regular basis.

- **Prior exposure to the humanities and medicine**[†]

Only eight respondents (28%) had previous exposure to the humanities and medicine. They had been exposed during college (4/8) as well as the preclinical (5/8) and clinical years (4/8) of medical school. Two (6%) had prior experiences with the humanities and medicine during residency. This group had used fiction (7/8), poetry (4/8), music (3/8), drama (3/8), art (3/8) and film (2/8) in their prior studies. The humanities and medicine had been taught primarily in lectures (6/8) and seminars (3/8). The majority had been instructed by physicians (5/8) while the remainder were taught by professors or visiting lecturers.

The majority felt their instructors had sufficient expertise (5/8) and that their exposure had been appropriately timed in their studies (7/8). They tended to feel as if the exposure lacked depth in discussing the arts (5/8). They were divided on its relevance to clinical medicine.

While the remaining 73% (21/29) responded that they had *not* been exposed to the humanities and medicine a majority (15/29) had attended Yale's Primary Care Program's "Medicine and the Arts" evenings. "Medicine and the Arts" consists of quarterly opportunities for faculty and house staff to mingle and discuss readings, music or art performed by various members of the medical community.

[†] Please refer to Methods section for the working definition of humanities and medicine.

- **Pre- and post-intervention attitudes: quantitative data**

The following data were gathered from the 26 residents and students (84%) who completed both pre- and post-intervention questionnaires. The residents and students rated their interest in learning about the humanities and medicine on a 5-point Likert Scale from no interest to very interested. Their mean interest was 3.7 both prior to (SD 1.1) and following (SD 1.0) the poetry curriculum. Attitudes toward time devoted to the humanities and medicine during residency on the wards and in other medical settings was evaluated. As shown in Tables 1 and 2, residents' attitudes toward these topics did not show a statistically significant change during the poetry curriculum. In both pre- and post-intervention questionnaires residents responded that they would enjoy time devoted to humanities and medicine in lectures or workshops. In both pre- and post-intervention

Would time devoted to the humanities and medicine ***on the wards***...	Pretest Mean (SD)	Posttest Mean (SD)	P-value
be useful or productive?	3.1 (1.2)	2.7 (1.1)	0.17
be enjoyable?	3.6 (0.8)	3.2 (1.3)	0.19
improve patient care?	3.2 (1.1)	2.8 (1.1)	0.23
improve house officers' abilities to talk to, understand and/or empathize with their patients?	3.4 (1.3)	3.3 (1.5)	0.77

Table 1. Responses of residents and students (n = 26) with matched pre- and post-intervention questionnaires. Responses on a 5 point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree or disagree, 4 = agree, 5 = strongly agrees). SD = standard deviation.

Would time devoted to humanities and medicine ***in lectures or workshops***...	Pretest Mean (SD)	Posttest Mean (SD)	P-value
be useful or productive?	3.8 (1.0)	3.4 (1.1)	0.19
be enjoyable?	4.2 (0.7)	4.0 (1.1)	0.46
improve patient care?	3.8 (1.0)	3.3 (1.3)	0.19

Table 2. Responses of residents and students (n=26) with matched pre- and post-intervention questionnaires. Responses on a 5 point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree or disagree, 4 = agree, 5 = strongly agrees). SD = standard deviation.

questionnaires, residents and students were neutral in their assessment of the utility and productivity of time spent on the wards devoted to the humanities and medicine. They were undecided as to the ability of time devoted to the humanities and medicine in improving patient care or house officers ability to talk to, understand or empathize with their patients. Following the poetry curriculum they were undecided whether the use of time devoted to the humanities and medicine in lectures or workshops was useful, productive or capable of improving patient care.

Most residents and students felt that their instructors had sufficient expertise (62%, 16/26) and that the project emphasized the appropriate issues (65%, 17/26). They felt that the intervention was introduced neither too early nor too late during medical training (96%, 23/24).

No resident or student characteristic (including level of training, type of resident, gender, age, native language, foreign training, prior exposure to the humanities and medicine, or empathy scores) was related to either a positive or negative change in attitude toward time devoted to the humanities and medicine on the wards. In addition, no attending physician baseline characteristic or change in attitude was related to their residents and students' change in attitude.

- **Medical empathy scale**

Before the curriculum the residents and students' mean medical empathy score was 42.6 (SD 4.7, range 36-53). On the post-intervention questionnaires they scored 42.8 (SD 4.5, range 34-55) with a mean nonsignificant change of +0.17 ($P < 0.83$).

Interestingly, there was a trend toward greater interest in the humanities and medicine according to an individual's empathy score. For example, residents who scored 45 and above had a mean interest of 4.0, while residents with scores of less than 39 had a mean interest of 3.3 and the intermediate scores also had a intermediate level of interest of 3.8.

Attending Physicians

- **Baseline characteristics**

The seven participating attending physicians had a mean age of 41.1 years (range 31 to 55) and were all internists, three of whom had completed fellowships in general internal medicine (2) and infectious diseases (1). The four eligible attending physicians who did not participate had a mean age of 42 years (range 32 to 48) and were internists, two of whom had completed fellowships one each in nephrology and gastroenterology.

Given the small number of eligible attending physicians, it was not possible to determine any significant differences in the pre-intervention questionnaire responses between the participating and nonparticipating attending physicians.

- **Prior teaching experience**

Three of the 11 (27%) attending physicians had prior experience teaching the humanities and medicine. These three had used the humanities with house officers and medical students either during attending rounds, work rounds or case conferences. All three had used novels or short stories. One attending physician had used music and

poetry in addition to fiction. One of the attending physicians with prior experience did not participate. Therefore, two of the seven (29%) participating attending physicians had had previous informal experience teaching the humanities and medicine.

- **Pre- and post-intervention attitudes, comfort and expertise: quantitative data**

The attending physicians were equally enthusiastic about teaching the humanities and medicine both prior to (mean 4.0, SD 1.1) and following (mean 4.0, SD 0.9) the poetry curriculum. They were also comfortable teaching the humanities and medicine prior to and following the poetry curriculum. They rated their comfort on a Likert-five point scale from no comfort to very comfortable as 3.7 (SD 1.2) prior to and 4.1 (SD 1.1) following the poetry curriculum ($P<0.15$). Half of the attending physicians considered themselves to have the expertise to teach the humanities and medicine prior to the project. The physicians who participated evaluated their personal expertise as the same after completing the project.

The attending physicians evaluated time spent both on the wards and in other medical settings devoted to the humanities and medicine both prior to and following the curriculum. These data are shown in Tables 3 and 4. There were no statistically significant changes in attitudes toward time devoted to the humanities and medicine. The attending physicians agreed both prior to and following the intervention that time spent in lectures or workshops devoted to humanities and medicine would be useful, productive, enjoyable and would improve patient care. Following the intervention, the attending physicians felt that time devoted to the humanities and medicine on the wards was both

Would time devoted to the humanities and medicine ***on the wards***...	Pretest Mean (SD)	Posttest Mean (SD)	P-value
be useful or productive?	3.6 (0.8)	3.3 (1.1)	0.59
be enjoyable?	4.1 (0.7)	4.0 (1.0)	0.76
improve patient care?	3.6 (0.8)	3.0 (1.0)	0.26
improve house officers' abilities to talk to, understand and/or empathize with their patients?	—	3.7 (0.8)	—

Table 3. Responses of attending physicians (n=7) with matched pre- and post-test questionnaires. Responses on a 5 point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree or disagree, 4 = agree, 5 = strongly agrees). SD = standard deviation.

Would time devoted to humanities and medicine ***in lectures or workshops***...	Pretest Mean (SD)	Posttest Mean (SD)	P-value
be useful or productive?	3.9 (0.7)	4.1 (0.9)	0.45
be enjoyable?	4.3 (0.5)	4.7 (0.5)	0.13
improve patient care?	3.7 (0.8)	3.7 (1.0)	1.00

Table 4. Responses of attending physicians (n=7) with matched pre- and post-test questionnaires. Responses on a 5 point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree or disagree, 4 = agree, 5 = strongly agrees). SD = standard deviation.

enjoyable and capable of improving residents ability to talk to, understand, and/or empathize with their patients. However, following the poetry curriculum attending physicians were undecided whether time spent with the humanities and medicine on the wards was useful, productive or capable of improving patient care.

Attending physicians generally felt that too much time had been allotted to the project (4/5). The majority felt the discussions were analytical enough (4/6), had sufficient depth (5/6) and emphasized the appropriate issues (6/7). The attending physicians were divided on the curriculum's relevance to clinical medicine.

Qualitative Responses: Residents, Students and Attending Physicians

- **Usefulness of poems and packets**

Eleven (39%) of the residents and students described specific packets or poems as particularly useful. These included the packets on Death and dying, AIDS and Anger as well as Raphael Campo's "The distant moon", William Carlos Williams' "The last words of my English grandmother", Donald Hall's "The ship pounding" and poems by Emily Dickinson.

The attending physicians pointed to similar poems as being useful including those by Williams, Campo, Dickinson and Hall. They also found poems by Dylan Thomas, Lisel Mueller, Jack Coulehan, Maya Angelou among others to be useful as well. Some noted that "each poem discussed was useful".

The majority (15/19) of residents and students felt that the written materials accompanying the poems were useful and noted that "they placed poems in context nicely," "very carefully chosen poems," and "helpful discussion guidelines." The minority (4/19) did not find the written materials useful, but did not give specific reasons. All of the attending physicians (7/7) felt that the written materials were useful. They found "the real-world connections of the poet" interesting and the packets "very well organized and presented".

- **Addressing specific clinical situations through poetry discussions**

Many of the residents and students noted that their poetry discussions had been useful in addressing a specific clinical situation. Death and dying, refusal of medical

therapy, difficult patients, addictions, aging, cancer and depression were some of the clinical problems which had been addressed through the poetry. Specific examples included Sylvia Plath's poem "Tulips" which facilitated discussion of the team's approach to a depressed, young female addict who wanted to sign out against medical advice; discussion of Donald Hall's "The ship pounding" addressed the needs of the children of a patient with acute lymphoblastic leukemia; and Robert Watson's "At the doctor's" facilitated discussion of the anger of a patient with recently diagnosed lung cancer who refused to allow house officers to speak to him.

Some residents wrote that their discussions did not focus on specific clinical situations, but that the discussions were "helpful in keeping us aware of physical and emotional pain of patients" and aware of "ethical aspects in medicine which are very important to discuss during residency training." However, two residents wrote that "poetry is not necessary for ethics discussions" and "it did not add to or change anyone's views."

Three of the seven attending physicians believed that discussions had addressed specific situations on the wards, including refusal of care, angry patients, and patients in severe pain. Two attending physicians felt the discussions had addressed their clinical situations only indirectly, and two attending physicians did not believe their discussions had addressed specific clinical situations. One of the latter noted that "the house staff are already very sensitive to the patient's needs/emotional states."

- **Attending physician as facilitator**

The majority (21/24) of the residents and students felt that the attending physician had been helpful in facilitating discussions. All of the specific positive comments were reserved for one attending physician. He was described as "very versed in the humanities and medicine." Another resident of his replied, "he is very open-minded—so can act as a great facilitator and readily sees everyone's opinion as valid—which is very important if residents want to feel they can really express themselves without being judged". The student who had participated in the project with more than one attending physician wrote, "the quality of discussions is often dependent not on the attending's 'expertise' but rather his or her enthusiasm."

At least two residents and/or students from every team responded that their attending physician had been helpful in facilitating discussions. However, the other open-ended responses seemed to demonstrate that either positive or negative experiences predominated in individual teams. In three of the teams, residents and students' responses to the open-ended questions were positive. In the four other teams, the residents and students' responses to the open-ended questions were either mixed or negative. Using chi-square analyses, there was no attending physician baseline characteristic or attitude which correlated with the teams with only positive experiences.

- **Residents as facilitators**

Four attending physicians felt that the residents had been helpful in facilitating discussions, for example "they were very insightful," while two attending physicians felt that their residents had not been helpful.

- **Best and worst aspects of curriculum**

The residents and students' felt the best aspect was "stimulating discussions" and improved "group dynamics". In addition, several residents and students described the curriculum as providing an opportunity to apply the poetry discussion to specific patients and represented a "pleasant shift in gears". Other residents responded that the curriculum was "fun and interesting" and fostered "a different kind of knowledge." Another resident enjoyed that "everyone said something and no one was right or wrong." One resident wrote, "discussing poetry helped me to recognize some of my reactions as something that others have to handle too."

Attending physicians had similar responses noting that the topics and quality of the discussions were the best aspects of the project. Many attending physicians commented on the ability of the poetry discussions to raise "issues that otherwise most often, but not always, remain outside of ward discussions". Poetry was described as "an effective catalyst for persons to share their own feelings, which we don't do often enough especially during attending rounds". Another attending physician commented that "this [curriculum] introduced the residents to many emotions, perspectives and an awareness of themselves and their patients". Another attending physician noted that the curriculum presented an opportunity to "look at our lives and our patients' lives from a different perspective" and noted that "from these very bright house staff there was a marvelous sense of awareness and introspection".

Several attending physicians commented on the positive effect on the team's relationships. The discussions were noted to "increase the depth of [the residents'] relationships, both professional and personal".

Several residents and students felt that the worst aspect of the poetry curriculum was that the discussions decreased time to learn pathophysiology and other clinical topics. For example, one resident wrote that the discussions "cut into attending lectures on more relevant clinical issues". One resident responded that she "loves poetry, arts, humanities, etc." but "it is essential to prioritize my time while on the wards and humanities is at the lowest spot possible." Following lack of time, the next most common problem was the reticence or ambivalence of other residents and students toward the project. For example, one of the residents wrote, "worse is the trepidation people have of expressing their own opinions". One student noted that the "lack of willingness to be open and honest, sometimes obstructed discussions, and turned it into sarcastic chatting". "Not understanding a poem" and "poems that did not correspond well with a clinical topic" were described as weaknesses of the curriculum.

Every attending physician felt that the worst aspect of the project was the lack of time on the wards and the feeling of being rushed. One lamented that "it was difficult sometimes to resist a 'let's read the poem and get on with more pressing matters' attitude." Each of the following was mentioned by one attending physician as a weakness of the curriculum: "somewhat forced and artificial" topics, difficulty in matching patients and poems, and the residents' inhibitions toward openly discussing their feelings.

Another attending physician noted that it was difficult to begin the curriculum early in the year with interns who were not yet comfortable in the hospital.

- **Suggestions to improve the curriculum**

The residents and students most frequently suggested improving the curriculum by increasing the available resources of poetry and handing out the poems earlier. Several also suggested improving the curriculum by moving the discussions off the wards, e.g. an ambulatory setting, noon conference or resident report. Other residents suggested decreasing the frequency and time devoted to discussing poetry on the wards. Two residents felt that attendance should be optional. In response to the question of how to improve the project, two residents suggested canceling it. Another wrote that the curriculum should be applied to medical students or attending physicians, not residents.

All seven attending physicians focused on solving the problem of limited time on the wards. They suggested either less frequent discussions on the wards or moving the discussions to another venue that would be less rushed. They also suggested that the curriculum is best when used with a team that has established a level of trust. An attending physician suggested speaking to the residents about their interests and needs before beginning the curriculum. Other suggestions included increasing the availability of poetry and complementing the poetry discussions with other hospital-based humanities projects.

- **Responses of attending physicians who did not participate**

Two of the four attending physicians who chose not to formally participate in the study went on to use the packets with their residents. They reported that the packets were useful in addressing specific clinical situations including working with a dying cancer patient and a patient in the terminal stages of AIDS.

The four attending physicians who chose not to participate all described lack of time as their reason not to participate. One attending wrote, "with only one month and the rotation of residents and interns during that time, I found I could do little more than hand out the poems". One attending physician, who had completed his residency three months prior to the start of the curriculum, had strong feelings about poetry on rounds, "I'm not against poetry, but I believe it is completely inappropriate to use attending rounds to discuss poetry." Another expressed his lack of faith in the whole venture, "I doubt there is a curriculum that can teach doctors to be compassionate and caring."

DISCUSSION

The medical education community has called for the training of physicians with humanistic qualities.[5, 117-119] The American Board of Internal Medicine declared that "the qualities [of] a physician should...include integrity, respect, compassion, honesty, trustworthiness, commitment, and humility" and emphasized the "unique" opportunity of residency training to "affect attitudes, behavior patterns, and moral conduct in medical care".[117] The poetry curriculum described in this paper provided case-based opportunities for the discussion, expression and teaching of humanistic qualities directly on the wards.

The success of the curriculum as "an effective catalyst" to raise humanistic issues in a case-based fashion was described by several attending physicians, residents and students. Although the curriculum occasionally succeeded in focusing on specific patients, poetry discussions of medical care in general were also found to be of value. Residents noted that the poetry "led to discussions about types of patients—difficult ones, addicted ones—that might not have been addressed otherwise". A resident noted the curriculum's ability to "keep us aware of the physical and emotional pain of our patients." And, an attending physician emphasized the value of the opportunity to look at "our patient's lives from different views".

Self-awareness is a quality essential to the humanistic physician[119] and was fostered during the intervention. One attending physician found that the curriculum "introduced the residents to many emotions, perspectives and an awareness of themselves." Another attending physician emphasized the "marvelous sense of awareness and introspection" that the residents displayed. A resident noted that the poetry curriculum "helped me to recognize some of my reactions as something that others have to handle too." In addition, a student recognized the ability of particular poems to "correspond not only to some of the clinical situations but the very intimate feelings in all of us."

In addition to encouraging the use of humanistic skills in addressing clinical situations, other benefits such as literary knowledge and enhanced team relationships were described by attending physicians and residents. Although the knowledge gained

through the discussions was not biomedical, many residents commented on the clinical usefulness of literary knowledge as "a different kind of knowledge". This knowledge might correspond to what Anne Hudson Hawkins has described as the insights and perspectives of epiphany.[14] Also as Horowitz found when introducing poetry onto rounds,[62] relationships among team members were sometimes enhanced by the poetry readings and discussions. Residents commented on the curriculum's ability to "help people get to know one another". Residents enjoyed "talking to others on the team about another aspect of life...without being judged". Attending physicians valued the opportunity to place "everyone on equal footing" which enabled the curriculum to "enrich our relationships with one another".

The curriculum also succeeded in allowing several faculty members, who were interested but had no special expertise in literature and medicine, to use poetry as a tool on attending rounds. All attending physicians who chose to participate found the materials provided useful in allowing them to introduce literature onto attending rounds. One noted that he was "pleasantly surprised by the fact that simply reading a poem was relatively easy and nonthreatening for me (a novice) and gradually the house staff felt comfortable with the process..." Another described the curriculum as "great for untrained participants".

While at times the curriculum succeeded in facilitating case-based and global discussions of humanistic care, applying literary knowledge to care of hospitalized patients, strengthening team relationships, and allowing untrained attending physicians to bring literature into ward rounds, the quantitative, matched data revealed no change in attitudes toward time devoted to the humanities and medicine. There are several possible explanations for the lack of change: 1) the curriculum's success in facilitating clinically relevant discussions might not have occurred on a frequent enough basis to effect change in attitudes; 2) the humanistic aspects of care were successfully addressed, but residents and students did not view this objective as a sufficiently practical use of time on the wards or sufficiently relevant to patient care; 3) alternatively, the small sample size of residents, students, and attending physicians was too small to demonstrate change in attitudes; 4) the instruments used to quantify change were either too imprecise, inaccurate

or insensitive to measure the changes in attitudes; and 5) the barriers to introducing the curriculum were not overcome. These barrier were assessed in both pre- and post-intervention questionnaires and are useful to consider further.

The poetry curriculum faced formidable barriers which were, at times, not sufficiently overcome. The lack of time on the wards, which has been previously described,[114, 115] was found to be the most difficult barrier to overcome. Several steps had been taken during the preparation of the curriculum to overcome the lack of time on the wards. The curriculum had been streamlined to minimize preparation time. Poems were provided with introductory remarks allowing residents to avoid the extremely valuable, but time-consuming, process of finding clinically relevant poetry. Poetry was also chosen for its succinctness. However, the instruction to discuss poetry twice a week for three weeks during attending rounds was a large commitment of the team's time. These frequent discussions during the intervention, encouraged to ensure sufficient exposure to the curriculum, may have more than counteracted the poetry curriculum's brevity. Attending physicians also pointed to logistical concerns, such as some interns switching after two weeks and new interns starting on the wards, as problems that aggravated the lack of time.

However, the lack of time was not the only barrier to the introduction of the poetry curriculum. Negative attitudes and inhibition of residents and students were important as well. Although the mean level of interest in the humanities and medicine was relatively high among residents (3.7/5.0), residents' lack of willingness to openly discuss issues was one of the most common problems identified by residents and students. Residents described stifled discussions because of "inhibited...participants" and "the trepidation people have of expressing their own opinion". One student perceived that the "lack of willingness to be open and honest" was the major obstacle to productive discussions. An attending physician described the "unwillingness of some residents to be involved in the discussion". A contributing factor to the residents' attitudes might be that some residents do not consider the 'humanization' of physicians a topic relevant to the clinical practice of medicine. Or, alternatively, some residents might feel as one of the

nonparticipating attending physicians did, that poetry was not an appropriate vehicle to use to address the humanistic aspects of the practice of medicine.

A minority of the attending physicians shared the negative attitudes of the residents. One thought that a curriculum focused on humanistic skills was unnecessary because "the house staff are already very sensitive to the patients' needs / emotional states." While a nonparticipating attending physician wrote, "I doubt there is a curriculum that can teach doctors to be compassionate and caring."

The unwilling participants were probably an important component in the overall reaction to the curriculum. The random distribution of residents and students may have created teams that were not open, and possibly hostile, to introducing novel approaches to teaching on the wards. To address this barrier, attending physicians might need to carefully select not only the appropriate clinical situations, but also assess team dynamics for maximizing the utility of the curriculum. One attending physician noted that a level of trust and team cohesiveness was necessary before the curriculum could be effectively applied to clinical situations.

In addition to these significant barriers, and most likely contributing to them, the poetry curriculum's relevance to the practice of clinical medicine must be firmly endorsed by faculty and residents for its successful incorporation into the residency curriculum. The quantitative responses clearly demonstrated that the majority of the residents and students, as well as half of the faculty, were undecided about the curriculum's relevance to clinical medicine.

The structure and design of the curriculum must, at least in part, be held responsible for the perceived insufficient relevance to clinical medicine. Since attending physicians were instructed to hold two discussions a week, clinically appropriate topics were not always available. Attending physicians commented on the lack of "available patients to talk about" and the "somewhat forced and artificial" categories. As well as aggravating the lack of time, the frequency of discussions may have diluted the curriculum's clinical relevance. When clinically relevant situations were lacking, the frequent biweekly discussions might have contributed to the residents and students' ambivalence toward humanities and medicine's relevance to patient care.

There are several changes to the implementation of the poetry curriculum that might overcome these barriers. The primary change would be a highly selective use of the curriculum by interested faculty members. Less frequent discussions addressing particularly challenging clinical situations should be used. In addition, faculty would be in a position to select not only the clinical situation but also the appropriate team with which to use the poetry curriculum. Placing the curriculum in a clinical setting in which there is more time available for discussion such as an outpatient clinic might also be productive. The curriculum might benefit from more extensive faculty development or the involvement of specialists in the field of literature and medicine.

In conclusion, this innovative, case-based, modular poetry curriculum succeeded in using discussions of poems to address specific clinical issues on the wards as well as patient care in general. The curriculum was seen by many as an effective vehicle to stimulate discussions of humanistic aspects of clinical topics which, although important to patient care, are usually absent from attending rounds. Additional potential benefits of the curriculum included fostering self-awareness and enhancing team dynamics. Faculty members not versed in the humanities and medicine were able to use the curriculum successfully. Despite specific successes described above, resident, student and attending physician attitudes toward time devoted to the humanities and medicine did not change over the course of the intervention. Barriers potentially responsible for the lack of change of attitudes included lack of time, negative resident attitudes and lack of perceived relevance to clinical medicine. Suggested solutions for overcoming these barriers include: (1) less frequent and more selective use of the curriculum in the inpatient setting; (2) inclusion of the curriculum in the ambulatory setting; (3) further faculty development focused on teaching of the humanities in residency education; and (4) research of residents' attitudes including the clinical relevance and importance of incorporating the humanistic qualities of physicians into residency training.

REFERENCES

1. Broyard A. Intoxicated by my illness: and other writings on life and death. New York: Fawcett Columbine, 1992.
2. Peabody FW. The care of the patient. JAMA 1927; 88:877-82.
3. Pellegrino ED. The affinities of medicine and literature. In: Peschel ER, ed. Medicine and literature. New York: Neale Watson Academic Publication, 1980.
4. Pellegrino ED. Educating the humanist physician: an ancient ideal reconsidered. JAMA 1974; 227:1288-94.
5. Subcommittee on evaluation of humanistic qualities in the internist. A guide to awareness and evaluation of humanistic qualities in the internist. Portland, Oregon: American Board of Internal Medicine, 1985.
6. Fraser D, Smith LJ. Unmet needs and unused skills: physicians' reflections on their liberal arts education. Acad Med 1989; 64:532-37.
7. Reiser SJ. Science, pedagogy, and the transformation of empathy in medicine. In: Spiro H, Curnen MG, Peschel E, St.James D, eds. Empathy and the practice of medicine. New Haven: Yale University Press, 1993:121-32.
8. Hunter KM. Toward the cultural interpretation of medicine. Literature and medicine 1991; 10:1-17.
9. Trautmann J. Healing arts in dialogue: medicine and literature. Carbondale: Southern Illinois University Press, 1981.
10. Self DJ. The role of the humanities in medical education. Norfolk: Teagle & Little, Inc., 1978:73.
11. Charon R, Banks JT, Connelly JE, et al. Literature and medicine: contributions to clinical practice. Ann Intern Med 1995; 122:599-602.
12. Rabuzzi DA. Literature and medicine: toward a new discipline. Vol. 1. Albany: State University of New York Press, 1982.
13. Hunter KM, Charon R, Coulehan JL. The study of literature in medical education. Acad Med 1995; 70:787-94.
14. Hawkins AH. Literature, medical ethics, and 'epiphanic knowledge'. Journal of Clinical Ethics 1994; 5:283-90.
15. Trautmann J. The wonders of literature in medical education. In: Self DJ, ed. The role of humanities in medical education. Norfolk: Teagle & Little, Inc., 1978:32-44.
16. Jones AH. Literature and medicine: traditions and innovations. In: Clarke B, Aycock W, eds. The body and the text: comparative essays in literature and medicine. Lubbock, Texas: Texas Tech University Press, 1990:11-24.
17. Jones AH. Literature as mirror or lamp? [editorial]. Journal of Clinical Ethics 1994; 5:340-41.
18. Coles R. The call of stories: teaching and the moral imagination. Boston: Houghton Mifflin Company, 1989.
19. Moore AR. Medical humanities: an aid to ethical discussions. Journal of medical ethics 1977; 3:26-32.
20. Hunter K, Axelsen D. The Morehouse human values in medicine program, 1978-1980: reinforcing a commitment to primary care. J Med Educ 1982; 57:121-3.
21. Longhurst M. The doctor-patient relationship. In: Gilchrist VJ, Wear D, eds. Literature in medicine monograph. Kansas City, MO: Society of Teachers of Family Medicine, 1995.
22. Keller AH. Yossarian, Little Eva and other famous medical educators: what happens when residents study death through literature. In: Gilchrist VJ, Wear D, eds. Literature in medicine monograph. Kansas City, MO: Society of Teachers of Family Medicine, 1995:169-73.
23. Marks SC, Bertman SL. Experiences with learning about death and dying in the undergraduate anatomy curriculum. J Med Educ 1980; 55:48-52.
24. Cady J. Teaching about AIDS through literature in a medical school curriculum. In: Pastore JL, ed. Confronting AIDS through literature. Chicago: University of Illinois Press, 1993:233-48.
25. Moore AR. The missing medical text. Melbourne: Melbourne University Press, 1978.
26. Gilghrist VJ, Wear D. Literature in medicine monograph. Kansis City, MO: Societry of Teachers of Family Medicine, 1995.
27. Hatchett R. Suffering, literature, and the art of medicine. Pharos 1992; 55:13-17.

28. Charon R. The narrative road to empathy. In: Spiro H, Curnen MG, Peschel E, St.James D, eds. Empathy and the practice of medicine. New Haven: Yale University Press, 1993:147-59.
29. Drossman DA. The problem patient: evaluation and care of medical patients with psychosocial disturbances. Ann Intern Med 1978; 88:366-72.
30. Stephens GG. Hilfiker, Arrowsmith, and Lydgate: literary examples of physician failure. In: Stephens GG, ed. Family practice in the 1980s. Kansis City: The Society of Teachers of Family Medicine Foundation, 1990:141-54.
31. Mann T. The magic mountain. New York: Random House, Inc, 1927.
32. Camus A. The Plague. New York: Vintage International, 1947.
33. Coles R. Medical ethics and living a life. NEJM 1979; 301:444-6.
34. Wear D, Nixon LL. The fictional world: what literature says to health professionals. Journal of Medical Humanities 1991; 12:55-64.
35. Hunter KM. Literature and medicine: standards for applied literature. In: Callahan D, Caplan AL, Jennings B, eds. Applying the humanities. New York: Plenum Press, 1985:289-304.
36. Terry JS, Gogel EL. Poems and patients: the balance of interpretation. Literature and Medicine 1987; 6:43-53.
37. Jones AH. Literature and medicine: narrative ethics. Lancet 1997; 349:1243-46.
38. Barbour A. Caring for Patients: A Critique of the Medical Model. Stanford: Stanford University Press, 1995.
39. Sontag S. Illness as Metaphor. New York: Double Day, 1978.
40. Sheldon SH, Noronha PA. Using classic mystery stories in teaching. Acad Med 1990; 65:234-5.
41. Gogel EL, Terry JS. Medicine as interpretation: the uses of literary metaphors and methods. Journal of Medicine and Philosophy 1987; 12:205-17.
42. Moulton-Barrett D. Teaching diagnosis through prose and poetry. Can Med Assoc J 1984; 130:928-29.
43. Hunter KM. Narrative. In: Reich WT, ed. Encyclopedia of Bioethics. Vol. 4. New York: Simon & Schuster Macmillan, 1995:1789-94.
44. Brody H. Stories of sickness. New Haven: Yale University Press, 1987.
45. Kleinman A. The Illness Narratives: Suffering, Healing and the Human Condition: BasicBooks, 1988.
46. King NMP, Stanford AF. Patient stories, doctor stories, and true stories: a cautionary reading. Lit Med 1992; 11:185-99.
47. Hunter KM. Doctors' Stories: The Narrative Structure of Medical Knowledge. Princeton: Princeton University Press, 1991.
48. Charon R. Narrative contributions to medical ethics. In: DuBose ER, Hamel RP, O'Connell LJ, eds. A Matter of Principles?: ferment in US bioethics. Valley Forge, PA: Trinity Press International, 1994:260-83.
49. Jones AH. Literature and medicine: an evolving canon. Lancet 1996; 348:1360-62.
50. Jones AH. Literary value: the lesson of medical ethics. Neohelicon 1987; 14:383-92.
51. Joyce J. Dubliners. New York: Random House, 1926.
52. Angoff N. Libby, 1997.
53. Stone J. In all this rain. Baton Rouge: Louisiana State University Press, 1980.
54. Campo R. The Other Man Was Me: A Voyage to the New World. Houston: Arte Público Press, 1994.
55. Lawrence SV. A profile of John Stone: the medical badge. Lit Med 1985; 3:115-25.
56. Hoffman D. Doctor and magus in the work of Dannie Abse. Lit Med 1985; 3:21-31.
57. Kreitman N. Medical themes in the poetry of Dannie Abse. Lit Med 1985; 3:47-52.
58. Collins M. Dannie Abse: poet-physician. Lit Med 1985; 3:71-4.
59. Trautmann J. Williams Carlos Williams and the poetry of medicine. Ethics in Sci Med 1975; 2:105-14.
60. Hunter KM. How to be a doctor: the place of poetry in medical education. Second Opinion 1991; 16:64-78.
61. Jones AH. Literature and medicine: physician-poets. Lancet 1997; 349:275-78.
62. Horowitz HW. Poetry on rounds: a model for the integration of humanities into residency training. Lancet 1996; 347:447-9.

63. McLellan MF. Literature and medicine: the patient, the physician, and the poem. Lancet 1996; 348:1640-2.
64. Coles R. Interlude: bringing poems to medical school teaching. In: Coles R, ed. The call of stories. Boston: Houghton Mifflin Company, 1989:92-101.
65. Campo R. personal communication, 1997.
66. McEntyre MC. Getting from how to why: a pause for reflection on professional life. Acad Med 1997; 72:1051-5.
67. Campo R. The Poetry of Healing: A Doctor's Education in Empathy, Identity, and Desire. New York: W.W.Norton & Company, 1997.
68. Philipp R, Robertson I. Poetry helps healing [letter]. Lancet 1996; 347:1046-47.
69. Smith HM. A double life. MD 1984:108-10, 113.
70. Ramsey J. The poetry and drama of healing: the Iroquoian condolence ritual and the Navajo night chant. Lit Med 1989; 8:78-99.
71. Philipp R, Coppell K, Freeman H. Poetry and the art of medicine [letter]. BMJ 1994; 308:63.
72. Abse D. More than a green placebo. Lancet 1998; 351:362-4.
73. Levertov D. Paper for literature and medicine symposium. In: Trautmann J, ed. Healing arts in dialogue: medicine and literature. Carbondale: Southern Illinois University Press, 1982:147-56.
74. Cousins N. The healing heart: antidotes to panic and helplessness. New York: Norton, 1983.
75. Billings JA, Coles R, Reiser SJ, Stoeckle JD. A seminar in 'plain doctoring'. Journal of Medical Education 1985; 60:855-59.
76. Moore AR. Medical humanities - a new medical adventure. NEJM 1976; 293:1479-80.
77. Blackwell B, Rodin AE, Nagy F, Reece RD. Humanizing the student-cadaver encounter. Gen Hosp Psych 1979; 1:315-21.
78. Wilson J, Blackwell B. Relating literature to medicine: blending humanism and science in medical education. General Hospital Psychiatry 1980; 2:127-133.
79. McElhinney TK. Human values teaching programs for health professionals: self-descriptive reports from twenty-nine schools. Philadelphia: Society for Health and Human Values, 1976.
80. Mathiasen H. Literature and medicine: the human experience. Am J Cardiol 1997; 79:1222-25.
81. Maccio ME, Garcia-Shelton LM. Family medicine and literature: a natural match. Family Systems Medicine 1985; 3:27-33.
82. Squier HA. Women and medicine. In: Gilchrist VJ, Wear D, eds. Literature in medicine monograph. Kansas City, MO: Society of Teachers of Family Medicine, 1995:193-200.
83. Swick H. The use of literature in teaching roles and responsiblities of physicians. In: Gilchrist VJ, Wear D, eds. Literature in medicine monograph. Kansas City, MO: Society of Teachers of Family Medicine, 1995:211-6.
84. Marshall PA, O'Keefe JP. Medical students' first-person narratives of a patient's story of AIDS. Soc Sci Med 1995; 40:67-76.
85. Bertman SL, Marks SC. The dissection experience as a laboratory of self-discovery about death and dying: another side of clinical anatomy. Clinical Anatomy 1989; 2:103-13.
86. Terry JS. The humanities and gross anatomy: forgotten alternatives. Journal of Medical Humanities and Bioethics 1985; 1:90-8.
87. Reifler DR. Narratives of gross anatomy. Lit Med 1996; 15:184-92.
88. Coulehan JL, Williams PC, Landis D, Naser C. The first patient: reflections and stories about the anatomy cadaver. Teaching and Learning in Medicine 1995; 7:61-6.
89. Coulehan J. Literature and empathy. In: Gilchrist VJ, Wear D, eds. Literature in medicine monograph. Kansas City, MO: Society of Teachers of Family Medicine, 1995:129-43.
90. Kopelman LM. Development of the medical humanities program at East Carolina University. Acad Med 1989; 64:730-4.
91. Calman KC, Downie RS, Duthie M, Sweeney B. Literature and medicine: a short course for medical students. Medical Education 1988; 22:265-69.
92. Charon R. To render the lives of patients. Lit Med 1986; 5:58-74.
93. Zarconi J, Kohn M. "I am not stupid. I was a teacher!" A narrative-based approach to clinical medical ethics teaching. In: Gilchrist VJ, Wear D, eds. Literature in medicine monograph. Kansas City, MO: Society of Teachers of Family Medicine, 1995:223-29.
94. Angoff N. Personal communication, 1998.

95. McGreevy JM. Liberal arts in the surgery residency. Acad Med 1992; 67:32-33.
96. Radwany SM, Adelson BH. The use of literary classics in teaching medical ethics to physicians. JAMA 1987; 257:1629-31.
97. Coles R. The humanities in postgraduate training [editorial]. JAMA 1987; 257:1644.
98. Boufford J. The teaching of humanities and human values in primary care residency training: an effort begins. Family Medicine 1982; 14:3-5.
99. Gilchrist VJ, Wear D. Introduction. In: Gilchrist VJ, Wear D, eds. Literature in medicine monograph. Kansas City, MO: Society of Teachers of Family Medicine, 1995:1-4.
100. Department of Internal Medicine. Yale University School of Medicine: residency training in primary care internal medicine 1998-1999. New Haven: Yale University School of Medicine, 1997.
101. Middleton J, Sen P, Middleton JR. Teaching humanistic behavior: humanities study in the internal medicine residency. New Jersey Medicine 1993; 90:763-66.
102. Swick T. A sentimental education for residents. Am Coll Physician Observer 1986; 6:15-16.
103. Shafer A, Fish MP. A call for narrative: the patient's story and anesthesia training. Lit Med 1994; 13:124-42.
104. Coulehan JL. Teaching the patient's story. Qualitative Health Reseach 1992; 2:358-66.
105. Stein HF. Playful uses of literature, art and other expressive culture in medical education. In: Gilchrist VJ, Wear D, eds. Literature in medicine monograph. Kansas City, MO: Society of Teachers of Family Medicine, 1995:201-9.
106. Wear D, Nixon LL. Scoot down to the edge of the table, hon: women's medical experiences portrayed in literature. Pharos 1991; 54:7-11.
107. Kohn M, Wear D, Saltzman G. Gathering facts and gathering visions: poetry from medical students. Lit Med 1985; 3:102-4.
108. Risse GB. Literature and medicine [editorial]. West J Med 1992; 156:431.
109. Coulehan J. The man with stars inside. Ann Intern Med 1997; 126:799-802.
110. Cady J. A common geography of mind: physicians in AIDS literature. Semin Neurology 1992; 12:70-4.
111. Aull F. Medicine and the arts. Acad Med 1997; 72:194-95.
112. Horowitz HW. Personal communication, 1997.
113. Barnard D. Making a place for the humanities in residency education. Acad Med 1994; 69:628-30.
114. Povar GJ, Keith KJ. The teaching of liberal arts in internal medicine residency training. J Med Educ 1984; 59:715-21.
115. Strong C, Connelly JE, Forrow L. Teachers' perceptions of difficulties in teaching ethics in residencies. Acad Med 1992; 67:398-402.
116. Linn LS, DiMatteo MR, Cope DW, Robbins A. Measuring physicians' humanistic attitudes, values, and behaviors. Medical Care 1987; 25:504-15.
117. Subcommittee on evaluation of humanistic qualities in the internist. Evaluation of humanistic qualities in the internist. Ann Intern Med 1983; 99:720-24.
118. Ende J, Kelley M, Sox H. The federal council of internal medicine's resource guide for residency education: an instrument for curricular change. Ann Intern Med 1997; 127:454-57.
119. Ende J, Kelly MA, Ramsey PG, Sox HC. Graduate education in internal medicine: a resource guide to curriculum development: Rederated Council for Internal Medicine, 1997.

Appendix A: Poetry used in Poetry Curriculum

1. Dying patients†
   a) Jane Kenyon "The sick wife" / Donald Hall "The ship pounding"*
   b) Thom Gunn "Lament"
   c) Dylan Thomas "Do not go gentle into that good night"*
   d) Emily Dickinson "Pain..." and "After great pain..."*
2. Patients who engender anger and/or disgust†
   a) Robert Watson "At the doctor's"
   b) William Carlos Williams "The last words of my English grandmother"*
   c) Anne Sexton "The doctor of the heart"
3. Patients with intractable pain
   a) Molly Peacock "Commands of love"*
   b) Maxine Kumin "Pain: 1967"
   c) Emily Dickinson "Pain-..." and "After great pain..."*
   d) Jack Coulehan "The knitted glove"
4. Patients who refuse medical therapy†
   a) Lisel Mueller "Monet refuses the operation"*
   b) Jack Coulehan "The man with stars inside"*
   c) Maya Angelou "The last decision"*
5. Patients adjusting to illness and the hospital setting
   a) Rafael Campo "Lost in the hospital"
   b) Sylvia Plath "Tulips"*
   c) William Matthews "We shall all be born again but we shall not all be saved"*
   d) Mona Van Duyn "In the hospital for tests"
6. Patients with AIDS†
   a) Rafael Campo "The distant moon"*
   b) Michael Lassell "How to watch your brother die"
   c) Mark Doty "Fog"
7. Patients with addictions
   a) Anne Sexton "The addict"
   b) Langston Hughes "Junior addict"
   c) John Stone "Confabulation"

---

* These poems were noted by an attending, resident, or student to be particularly useful in a clinical situation or stimulating an interesting discussion.

† These three packets were felt by attending physicians and residents to be the most useful in the hospital setting.

Appendix B: Bibliographic guide to American poetry and medicine

Anthologies of poetry and medicine:

Jon Mukand, ed. Articulations: The Body and Illness in Poetry. University of Iowa Press,1994.
An anthology of poems on medical themes. The poems are written, for the most part, by established authors, some of whom are also practicing physicians. These contemporary poems are recommended for their accessibility and diversity.

Anthologies of literature and medicine which include contemporary American poetry:

* Martin Kohn, Carol Donley, Delese Wear, eds. Literature and Aging: An Anthology. Kent State University Press, 1992.
* Richard Reynolds, John Stone, eds. On Doctoring: Stories, Poems, Essays. Simon & Schuster, 1991.
* Marian Gray Secundy, ed. Trials, Tribulations, and Celebrations: African-American Perspectives on Health, Illness, Aging and Loss. Intercultural Press, 1992.
* Joanne Trautmann, Carol Pollard, eds. Literature and Medicine: An Annotated Bibliography. Revised Edition. University of Pittsburg Press, 1982.

American poets who have written poetry relevant to medicine include:

William Carlos Williams. Williams was a pediatrician in Rutherford, New Jersey. He was also a poet who set out to create a specifically American poetics, based on rhythms and colorations of American speech, thought, and experience. Often drawing on his medical experiences in his poetry, Williams is the prototypical American physician-poet.

Sylvia Plath. Sylvia Plath struggled with mental illness throughout her life. She published several collections of poetry and the autobiographical The Bell Jar.. Her work is intimately tied to her struggle with depression. She also wrote poems addressing suicide, insomnia, and life in the hospital, all of which are thematically relevant to clinical medicine.

Anne Sexton. Sexton began writing poetry at the suggestion of her therapist. Notable for its frankness and intimacy, Sexton's poetry often explores topics that are relevant to medicine including suicide, depression, insomnia, the hospital, and death and dying. Her collection of poetry is published by Houghton Mifflin Company.

Marilyn Hacker. Hacker is a contemporary American poet who often explores the nature of identity. After her experience with breast cancer, she wrote the provocative collection 'Cancer Winter' which can be found in her book Winter Numbers .

Beyond these well-known poets there are many other contemporary poets whose work is directly relevant to medicine. Poets in this category include ***Rika Lesser, Audry Lord, Eve Sedgwick, Alice Jones,*** and ***Forest Hamer***. There are also several practicing physicians who write poetry relevant to the practice of medicine including ***John Stone*** and ***John Coulehan***.

Appendix B (Cont.)

Poetry of AIDS:

Rafael Campo. Possibly because he is a practicing physician himself, Campo's poetry of AIDS is very accessible for medical professionals. He is a Cuban-American internist in Boston. He has published two collections of poetry The Other Man Was Me and What the Body Told. He has also published a collection of essays entitled The Poetry of Healing. Much of his work, both poetry and prose, concerns issues of identity within medical, latino, and gay cultures.

Thom Gunn. Poet and teacher living in San Francisco, Gunn has written eloquently of the nature and devastation of AIDS. His most pertinent collection in this respect is The Man with Night Sweats. Gunn's stature in the American literary community should not deter an inexperienced reader from approaching his very accessible work.

Paul Monette. Monette was a modern gay poet who wrote extensively on AIDS. His most well-known work on this topic is a very complex series of elegies to his lover who died of AIDS, collected in Love Alone: 18 Elegies for Rog A more recent collection of his poetry is entitled West of Yesterday, East of Summer. A more accessable introduction to Monette's work is his collection of essays, Borrowed Time: An AIDS Memoir.

Other poets who have written eloquently of AIDS include ***David Bergman, Mark Doty, Michael Lassell*** and ***Heather McHugh***. Anthologies of AIDS poetry include Poets for Life (1989), edited by Michael Klein, and Things Shaped in Passing (1997), edited by Klein along with Richard McCann. Klein, in Poets for Life, collected previously published poetry as well as works written specifically for his collection. Rachel Hadas edited Unending Dialogue: Voices from an AIDS poetry workshop (1991) a collection of poems written for an AIDS-poetry workshop. Another resource is Steven Kruger's AIDS Narratives: Gender and Sexuality, Fiction and Science (1996) which includes a comprehensive bibliography of AIDS poetry published through the end of 1994.

Appendix C: Medical Empathy Scale

Medical Empathy Scale[†]

- I need to know "where my patients are coming from" in order to treat their medical conditions adequately.
- An important part of the care I provide to patients is emotional acceptance.
- I don't allow my patients to see my emotions. [R]
- Patients are frequently to blame for their poor health status. [R]
- There are times when I cannot pay full attention to what my patients are saying. [R]
- I try not to reject patients in any manner.
- It is difficult for me to "tune in" on some things patients tell me. [R]
- It is difficult for me to empathise with the problems of certain patients. [R]
- I have a genuine interest in patients as people.
- It is not difficult for me to concentrate on what patients are saying.
- I often find it necessary to conceal my feelings from patients. [R]
- It is critical that I am aware of my patients' life situation (life style, family, work, finances).

All items are rated on a five-point contnuum from strongly agree (5) to strongly disagree (1). Items identified by an [R] are reverse scored.

[†] The scale was developed and validated by Linn LS, DiMatteo MR, Cope DW, Robbins A. Measuring physicians' humanistic attitudes, values, and behaviors. Medical Care 1987; 25:504-15.

Appendix D: Resident Pre-intervention Questionnaire

Directions: Please complete all of the questions below by checking all appropriate answers in **bold,** circling all appropriate numbers, and filling in all appropriate blanks. You may check as many answers as are relevant for each question.

1. What is your level of training?
   - ☐1 **medical student**
   - ☐2 **PGY1**
   - ☐3 **PGY2**
   - ☐4 **PGY3**
   - ☐5 **other**_____

2. Are you a:
   - ☐1 **categorical-medicine resident**
   - ☐2 **primary care-medicine resident**
   - ☐3 **transitional year resident**
   - ☐4 **fourth year medical student/ subintern**
   - ☐5 **third year medical student**
   - ☐6 **other** please specify_____

3. Are you ☐1 **male** or ☐2 **female**.

4. What is your age? _____

5. What is your native language? ☐1 **English**, ☐2 **Spanish**, ☐3 **other** _____

6. Was your prior medical training:
   ☐ **in the US** or ☐ **abroad** please specify country _____

7. How many hours a week do you spend reading medical journals and texts? _____hrs

8. How many hours a week do you spend reading non-medical material (excluding magazines and newspapers)? _____hrs
   Do you spend this time reading:
   - **novels** ☐**yes** ☐**no**
   - **non-fiction** ☐**yes** ☐**no**
   - **drama** ☐**yes** ☐**no**
   - **poetry** ☐**yes** ☐**no**
   - **other** please specify_____.

9. During your college or university years, did you take courses in the following areas:
   - **literature** (excluding poetry and drama) ☐**yes** ☐**no**
   - **poetry** ☐**yes** ☐**no**
   - **music** ☐**yes** ☐**no**
   - **drama/theater** ☐**yes** ☐**no**
   - **film** ☐**yes** ☐**no**
   - **art/art history** ☐**yes** ☐**no**

Appendix D: Resident Pre-intervention Questionnaire

For the purposes of this survey the term '*humanities and medicine*' will be defined as *either* the field which incorporates both the study of the humanities (e.g. literature, art, film, drama, music, etc.) along with the study of medicine *or* any activity that incorporates the humanities in the practice of medicine.

10. Have you had any training or exposure (formal or informal) to the humanities and medicine? ☐**yes** or ☐**no** If you answered no, please skip to question 16.

11. If yes, was your training or exposure during

college/university	☐**yes** ☐**no**
preclinical years of medical school	☐**yes** ☐**no**
clinical years of medical school	☐**yes** ☐**no**
residency	☐**yes** ☐**no**

other please specify_____

12. The focus of the training or exposure to the humanities and medicine was on:

fiction	☐**yes** ☐**no**
poetry	☐**yes** ☐**no**
music	☐**yes** ☐**no**
drama	☐**yes** ☐**no**
film	☐**yes** ☐**no**
art	☐**yes** ☐**no**

other please specify _____.

13. What format or setting was used for training or exposure to the humanities and medicine?

lectures	☐**yes** ☐**no**
seminars	☐**yes** ☐**no**
retreats	☐**yes** ☐**no**
grand rounds	☐**yes** ☐**no**
case conferences	☐**yes** ☐**no**
working rounds	☐**yes** ☐**no**
attending rounds	☐**yes** ☐**no**

other please specify _____.

14. Who was your instructor in the humanities and medicine in any of the above formats? (Please check as many answers as are appropriate.)

attending physician	☐**yes** ☐**no**
house officer	☐**yes** ☐**no**
English professor	☐**yes** ☐**no**

other please specify_____

15. Please score your previous experience with the humanities and medicine on the following scale:

	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
insufficient relevance to clinical medicine	**1**	**2**	**3**	**4**	**5**
instructor had sufficient expertise	**1**	**2**	**3**	**4**	**5**
too early in the curriculum	**1**	**2**	**3**	**4**	**5**
too late in the curriculum	**1**	**2**	**3**	**4**	**5**
too much time allotted	**1**	**2**	**3**	**4**	**5**
too little time allotted	**1**	**2**	**3**	**4**	**5**
not analytical enough	**1**	**2**	**3**	**4**	**5**
emphasized the appropriate issues	**1**	**2**	**3**	**4**	**5**
lack of depth in the discussion of literature	**1**	**2**	**3**	**4**	**5**

other please specify _____

_____

16. Have you participated in the primary care humanities evenings during residency?
☐**yes** ☐**no**

17. How would you rate your interest in learning about the humanities and medicine during residency?
no interest **1.....2.....3.....4.....5** very interested

18. How strongly do you agree or disagree with the following, could time set aside during residency for ***lectures or workshops*** (e.g. retreats, case conferences, grand rounds, etc.) in the humanities and medicine:

	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
be useful/productive	**1**	**2**	**3**	**4**	**5**
be enjoyable	**1**	**2**	**3**	**4**	**5**
improve patient care	**1**	**2**	**3**	**4**	**5**

19. How strongly do you agree or disagree with the following, could time set aside during residency ***on the wards*** for discussions of humanities and medicine:

	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
be useful/productive	**1**	**2**	**3**	**4**	**5**
be enjoyable	**1**	**2**	**3**	**4**	**5**
improve patient care	**1**	**2**	**3**	**4**	**5**

20. Do you think that discussing poetry on the wards over extended periods of time (e.g. months) might improve house officers' abilities to talk to, understand and/or empathize with their patients?
strongly disagree **1.....2.....3.....4.....5** strongly agree

Appendix E: Resident post-intervention questionnaire

Directions: Please complete all of the questions below by checking all appropriate answers in **bold,** circling all appropriate numbers, and filling in all appropriate blanks. You may check as many answers as are relevant for each question. For the purposes of this survey the term 'humanities and medicine' will be defined as *either* the field which incorporates both the study of the humanities (e.g. literature, art, film, drama, music, etc.) along with the study of medicine *or* any activity that incorporates the humanities in the practice of medicine.

1. How would you rate your interest in learning more about the humanities and medicine during residency?
   no interest **1.....2.....3.....4.....5** very interested

2. How strongly do you agree or disagree with the following, could time set aside during residency for ***lectures or workshops*** (e.g. retreats, case conferences, grand rounds, etc.) in the humanities and medicine:

	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
be useful/productive	**1**	**2**	**3**	**4**	**5**
be enjoyable	**1**	**2**	**3**	**4**	**5**
improve patient care	**1**	**2**	**3**	**4**	**5**

3. How strongly do you agree or disagree with the following, could time set aside during residency ***on the wards*** for discussions of humanities and medicine:

	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
be useful/productive	**1**	**2**	**3**	**4**	**5**
be enjoyable	**1**	**2**	**3**	**4**	**5**
improve patient care	**1**	**2**	**3**	**4**	**5**

4. Do you think that discussing poetry on the wards over extended periods of time (e.g. months) might improve house officers' abilities to talk to, understand and/or empathize with their patients?
   strongly disagree **1.....2.....3.....4.....5** strongly agree

5. In anytime during the past three months has poetry been used by your team on the wards? □**yes** □**no**. If you answered **no**, please skip to question #17.

6. How many times in the last three months have you been exposed to discussions of poetry during attending rounds? _____

7. Have you *led* the discussion of poetry on the wards in the last three months? □**yes,** if **yes** how many times _____ □**no**

8. Please evaluate your recent experience with *poetry on rounds* on the following scale:

	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
insufficient relevance to clinical medicine	1	2	3	4	5
instructor had sufficient expertise	1	2	3	4	5
too early in the curriculum	1	2	3	4	5
too late in the curriculum	1	2	3	4	5
too much time allotted	1	2	3	4	5
too little time allotted	1	2	3	4	5
not analytical enough	1	2	3	4	5
emphasized the appropriate issues	1	2	3	4	5
lack of depth in the discussion of literature	1	2	3	4	5

other please specify _____

_____

9. Which of the poems did you find most useful? Why?_____

_____

10. Which poems were the least useful?_____

_____

11. Was any discussion of poetry on the wards useful in addressing a specific clinical problem? Please give specific examples._____

_____

_____

12. Did you find any poems on your own that you would recommend for using in the future?_____

13. Were the written materials useful? _____

_____

14. What were the best and worst aspects of the discussions? _____

_____

15. What would you do to improve the project? _____

_____

16. Was the attending helpful in facilitating discussions?_____

_____

Appendix F: Attending physician pre-intervention questionnaire

Directions: Please complete all of the questions below by checking all appropriate answers and circling all appropriate numbers. You may check as many answers as are relevant for each question. For the purposes of this survey the term 'humanities and medicine' will be defined as *either* the field which incorporates both the study of the humanities (e.g. literature, art, film, drama, music, etc.) along with the study of medicine *or* any activity that incorporates the humanities in the practice of medicine.

1. Have you previously taught the humanities and medicine? □**yes** □**no**, if you answered no, please skip to question # 6.

2. Did you instruct:
   faculty □yes □no
   house officers □yes □no
   medical students □yes □no
   other please specify _____

3. Was this teaching of the humanities and medicine in the format of:
   lectures □yes □no
   seminars □yes □no
   retreats □yes □no
   grand rounds □yes □no
   case conferences □yes □no
   working rounds □yes □no
   attending rounds □yes □no
   other please specify _____.

4. What forms of the humanities was the focus of your teaching?
   fiction □yes □no
   poetry □yes □no
   music □yes □no
   drama □yes □no
   film □yes □no
   art □yes □no
   other please specify _____.

5. Please briefly describe the teaching of the humanities and medicine that you have done:_____
   _____
   _____

6. How much interest do you have in teaching the humanities and medicine in the future?
   no interest **1.....2.....3.....4.....5** very interested

Appendix F: Attending physician pre-intervention questionnaire

7. How comfortable are you teaching the humanities and medicine?
   no comfort **1.....2.....3.....4.....5** very comfortable

8. Do you feel you have the expertise to teach the humanities and medicine?
   - ☐ **yes**
   - ☐ **no**

9. How strongly do you agree or disagree with the following, could time set aside during residency for ***lectures or workshops*** (e.g. retreats, case conferences, grand rounds, etc.) in the humanities and medicine:

	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
be useful/productive	**1**	**2**	**3**	**4**	**5**
be enjoyable	**1**	**2**	**3**	**4**	**5**
improve patient care	**1**	**2**	**3**	**4**	**5**

10. How strongly do you agree or disagree with the following, could time set aside during residency ***on the wards*** for discussions of humanities and medicine:

	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
be useful/productive	**1**	**2**	**3**	**4**	**5**
be enjoyable	**1**	**2**	**3**	**4**	**5**
improve patient care	**1**	**2**	**3**	**4**	**5**

11. Do you think that discussing poetry on the wards over extended periods of time (e.g. months) might improve house officers' abilities to talk to, understand and/or empathize with their patients?
    strongly disagree **1.....2.....3.....4.....5** strongly agree

Thank you for your time!

Appendix G: Attending physician post-intervention questionnaire

Directions: Please complete all of the questions below by checking all appropriate answers and circling all appropriate numbers. You may check as many answers as are relevant for each question. For the purposes of this survey the term 'humanities and medicine' will be defined as *either* the field which incorporates both the study of the humanities (e.g. literature, art, film, drama, music, etc.) along with the study of medicine *or* any activity that incorporates the humanities in the practice of medicine.

1. Did the packets provided make you feel comfortable facilitating and participating in discussions of poetry on rounds?
   no comfort **1.....2.....3.....4.....5** very comfortable

2. How much interest do you have in teaching the humanities and medicine in the future?
   no interest **1.....2.....3.....4.....5** very interested

3. How comfortable will you be teaching the humanities and medicine in the future?
   no comfort **1.....2.....3.....4.....5** very comfortable

4. Do you feel you have the expertise to teach the humanities and medicine?
   - ☐ **yes**
   - ☐ **no**

5. How strongly do you agree or disagree with the following, could time set aside during residency for ***lectures or workshops*** (e.g. retreats, case conferences, grand rounds, etc.) in the humanities and medicine:

	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
be useful/productive	**1**	**2**	**3**	**4**	**5**
be enjoyable	**1**	**2**	**3**	**4**	**5**
improve patient care	**1**	**2**	**3**	**4**	**5**

6. How strongly do you agree or disagree with the following, could time set aside during residency ***on the wards*** for discussions of humanities and medicine:

	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
be useful/productive	**1**	**2**	**3**	**4**	**5**
be enjoyable	**1**	**2**	**3**	**4**	**5**
improve patient care	**1**	**2**	**3**	**4**	**5**

7. Do you think that discussing poetry on the wards over extended periods of time (e.g. months) might improve house officers' abilities to talk to, understand and/or empathize with their patients?
   strongly disagree **1.....2.....3.....4.....5** strongly agree

Appendix G: Attending physician post-intervention questionnaire

8. How many times were you present for discussions of poetry on the wards? _____

9. Please evaluate your recent experience with *poetry on rounds* on the following scale:

	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
insufficient relevance to clinical medicine	1	2	3	4	5
instructor had sufficient expertise	1	2	3	4	5
too early in the curriculum	1	2	3	4	5
too late in the curriculum	1	2	3	4	5
too much time allotted	1	2	3	4	5
too little time allotted	1	2	3	4	5
not analytical enough	1	2	3	4	5
emphasized the appropriate issues	1	2	3	4	5
lack of depth in the discussion of literature	1	2	3	4	5

other please specify _____

_____

10. Which of the poems did you find most useful? Why?_____

_____

11. Which poems were the least useful? _____

_____

12. Was any discussion of poetry on the wards useful in addressing a specific clinical problem? Please give specific examples._____

_____

_____

13. Were you introduced to any poems that you would recommend for using in the future?_____

14. Were the written materials useful? _____

_____

15. What were the best and worst aspects of the discussions? _____

_____

_____

16. Were the residents helpful in facilitating the discussions?_____

_____

17. What would you do to improve the project? _____

_____

Appendix H: Introduction for residents included in packets

I. Introduction

We will be spending 15 to 20 minutes of attending rounds discussing one poem in relation to a specific clinical situation on the wards. ***Don't panic*** — this discussion requires no previous knowledge, understanding, or comfort with poetry. Hopefully, poetry will provide a common ground to discuss issues relevant to clinical medicine that may not be easily discussed using the medical literature alone.

II. Choosing a poem

In this packet, you will find three or four poems, each with an introductory coversheet. You may choose one of the poems in this packet or bring in a different poem to discuss. You may select your poem for any reason, keeping your patient in mind. You might want to begin the discussion by explaining why you chose the poem. In addition, you might want to give the poem to other members of your team to read ahead of time.

III. Analyzing your poem

Reading, understanding, thinking and discussing poetry is in many ways completely different from the biomedical model we are accustomed to using in the hospital. On the wards, we use clinical knowledge to narrow down differential diagnoses to uncover the truth and find solutions to complex problems. In complex poetry, there are no correct answers and a single interpretation is neither necessarily right nor wrong. In the language of poetry multiple meanings may exist simultaneously. We learn to live with uncertainty and ambiguity. A corollary of this is that there may not be simple conclusions to be drawn. As our personal experiences change, our understanding of a poem may change.

As you begin to read and think about the poem you selected, remember that your presentation will draw more from the connections you find between your poem, your patient and your personal experiences than your literary expertise. In other words, it will not be necessary to analyze your poem as if you were a literature graduate student.

Let your mind wander freely when you are thinking about the poem. There is *not a right answer* when understanding poetry. For each poem there may be many themes and interpretations. Assume that each word, phrase and sentence has multiple meanings. If readers have different points of view, they may all be correct. There are some interpretations that might be more convincing than others, but the goal of the discussion will be to provide a comfortable environment to share different points of view. If the poem suggests something to you, it is worthy of discussion. Ezra Pound has described poetry as "language charged with meaning to the utmost possible degree." Therefore, don't hold back in your interpretations and associations.

Here are some pointers to keep in mind when considering your poem: 1) read your poem; 2) take a deep breath; 3) reread your poem and think about it; 4) do not get hung-up on parts of the poem you do not understand—you do not need to understand everything about the poem.

Aspects of the poem you may want to consider include: 1) the content; 2) the themes (there usually will be several); 3) the narrator's perspective; 5) what issues, concerns, and perspectives does the poem raise in the context of your clinical scenario; 6) your emotional response to the poem and your emotional response to your patient.

Although it is not necessary, if you are so inclined you may wish to address some of the literary aspects of your poem. You may want to assess the tone (attitude of the author toward his or her subject), and the complexity of the language (syntax, rhythm, word choice, meter, metaphors, analogies).

IV. Presenting your poem

The most important aspects of a successful presentation will be simply to have photocopied the poem for all members of the group, read the poem out loud at the onset, and provide an open and supportive environment for the discussion. The team might not know where to begin the discussion after you have read the poem aloud. Come prepared with some thoughts and comments. An introduction may be to simply begin by talking about what you liked, or disliked, in the poem and why you chose it.

An important part of the discussion will be connecting your poem back to your patient. Sometimes the clinical scenario will be strikingly similar in the poem and the connections will be obvious. However, most of the time the connections may not be very clear. In these cases, it might be easier to think of the poem as an analogy, metaphor, or allegory of your clinical situation. There are many other ways to connect the poem to the clinical situation: for example, you could consider the perspective in the poem and consider how that perspective may, or may not, be similar to your patient's. Another approach would be to consider the feelings, concerns and anxieties that reading this poem might evoke for the team with respect to this clinical situation, or how your patient might feel if he or she were to read the poem.

Above all, have fun with the experience. Remember that the style and format of the presentations are open to your own creativity and interests. Enjoy them!

Poetry on rounds

AIDS

Table of Contents

Poetry on Rounds:
AIDS

Pieter Cohen
Yale Medical School

How to approach your poem

I. Introduction

We will be spending 15 to 20 minutes of attending rounds discussing one poem in relation to a specific clinical situation on the wards. ***Don't panic*** — this discussion requires no previous knowledge, understanding, or comfort with poetry. Hopefully, poetry will provide a common ground to discuss issues relevant to clinical medicine that may not be easily discussed using the medical literature alone.

II. Choosing a poem

In this packet, you will find three or four poems, each with an introductory coversheet. You may choose one of the poems in this packet or bring in a different poem to discuss. You may select your poem for any reason, keeping your patient in mind. You might want to begin the discussion by explaining why you chose the poem. In addition, you might want to give the poem to other members of your team to read ahead of time.

III. Analyzing your poem

Reading, understanding, thinking and discussing poetry is in many ways completely different from the biomedical model we are accustomed to using in the hospital. On the wards, we use clinical knowledge to narrow down differential diagnoses to uncover the truth and find solutions to complex problems. In complex poetry, there are no correct answers and a single interpretation is neither necessarily right nor wrong. In the language of poetry multiple meanings may exist simultaneously. We learn to live with uncertainty and ambiguity. A corollary of this is that there may not be simple conclusions to be drawn. As our personal experiences change, our understanding of a poem may change.

As you begin to read and think about the poem you selected, remember that your presentation will draw more from the connections you find between your poem, your patient and your personal experiences than your literary expertise. In other words, it will not be necessary to analyze your poem as if you were a literature graduate student.

Let your mind wander freely when you are thinking about the poem. There is *not a right answer* when understanding poetry. For each poem there may be many themes and interpretations. Assume that each word, phrase and sentence has multiple meanings. If readers have different points of view, they may all be correct. There are some interpretations that might be more convincing than others, but the goal of the discussion will be to provide a comfortable environment to share different points of view. If the poem suggests something to you, it is worthy of discussion. Ezra Pound has described poetry as "language charged with meaning to the utmost possible degree." Therefore, don't hold back in your interpretations and associations.

Here are some pointers to keep in mind when considering your poem: 1) read your poem; 2) take a deep breath, 3) reread your poem and think about it; 4) do not get hung-up on parts of the poem you do not understand—you do not need to understand everything about the poem.

Aspects of the poem you may want to consider include: 1) the content; 2) the themes (there usually will be several); 3) the narrator's perspective; 5) what issues, concerns, and perspectives does the poem raise in the context of your clinical scenario; 6) your emotional response to the poem and your emotional response to your patient.

Although it is not necessary, if you are so inclined you may wish to address some of the literary aspects of your poem. You may want to assess the tone (attitude of the author toward his or her subject), and the complexity of the language (syntax, rhythm, word choice, meter, metaphors, analogies).

IV. Presenting your poem

The most important aspects of a successful presentation will be simply to have photocopied the poem for all members of the group, read the poem out loud at the onset, and provide an open and supportive environment for the discussion. The team might not know where to begin the discussion after you have read the poem aloud. Come prepared with some thoughts and comments. An introduction may be to simply begin by talking about what you liked, or disliked, in the poem and why you chose it.

An important part of the discussion will be connecting your poem back to your patient. Sometimes the clinical scenario will be strikingly similar in the poem and the connections will be obvious. However, most of the time the connections may not be very clear. In these cases, it might be easier to think of the poem as an analogy, metaphor, or allegory of your clinical situation. There are many other ways to connect the poem to the clinical situation: for example, you could consider the perspective in the poem and consider how that perspective may, or may not, be similar to your patient's. Another approach would be to consider the feelings, concerns and anxieties that reading this poem might evoke for the team with respect to this clinical situation, or how your patient might feel if he or she were to read the poem.

Above all, have fun with the experience. Remember that the style and format of the presentations are open to your own creativity and interests. Enjoy them!

Rafael Campo attended Amherst College in Massachusetts. After graduating from Harvard medical school, he completed his residency in Internal Medicine at UCSF and moved to Boston as faculty at Beth Israel Hospital. He has published two collections of poetry *The Other Man Was Me* and *What the Body Told* and one collection of essays. As a Cuban-American and gay man, Campo often deals with issues of sexual identity and cultural identity. As a gay physician in the 1990's, he explores the patient-physician relationship in the era of AIDS.

When Campo commented on his own poem "The distant moon," he has emphasized two themes: patients caring for physicians and the confidentiality of the doctor-patient relationship. As he cared for the patient in "The distant moon" during his residency, Campo recalls the care that his patient took of him, allowing him to come and read his poetry at his bedside. When writing and publishing stories of his patients, Campo often struggles with needs of privacy within the doctor-patient relationship.

Possible questions and suggestions to think about while reading "The distant moon" include:

* In the poem, what is the nature of the patient-physician relationship?
* What aspects of the relationship are healthy? Are there any drawbacks to the intimacy or distance in the relationship?
* What is the nature of 'community' in this poem about AIDS?
* What is the nature of the narrator's dream? Why does the narrator see the reflected image of the moon?
* Here and elsewhere Campo has written about his experiences reading poetry to his patients during residency. What do you think of reading poetry to patients?
* How does this poem relate to patients you are caring for?

[Note: Richard Howard, who is mentioned in the poem, is another contemporary American poet.]

The Distant Moon

I.

Admitted to the hospital again.
The second bout of pneumocystis back
In January almost killed him; then,
He'd sworn to us he'd die at home. He baked
Us cookies, which the student wouldn't eat,
Before he left—the kitchen on 5A
Is small, but serviceable and neat.
He told me stories: Richard Gere was gay
And sleeping with a friend of his, and AIDS
Was an elaborate conspiracy
Effected by the government. He stayed
Four months. He lost his sight to CMV.

II.

One day, I drew his blood, and while I did
He laughed, and said I was his girlfriend now,
His blood-brother. "Vampire-slut," he cried,
"You'll make me live forever!" Wrinkled brows
Were all I managed in reply. I know
I'm drowning in his blood, his purple blood.
I filled my seven tubes; the warmth was slow
To leave them, pressed inside my palm. I'm sad
Because he doesn't see my face. Because
I can't identify with him. I hate
The fact that he's my age, and that across
My skin he's there, my blood-brother, my mate.

III.

He said I was too nice, and after all
If Jodie Foster was a lesbian,
Then doctors could be queer. Residual
Guilts tingled down my spine. "OK, I'm done,"
I said as I withdrew the needle from
His back, and pressed. The CSF was clear;
I never answered him. That spot was framed
In sterile, paper drapes. He was so near
Death, telling him seemed pointless. Then, he died.
Unrecognizable to anyone
But me, he left my needles deep inside
His joking heart. An autopsy was done.

IV.

I'd read to him at night. His horoscope,
The New York Times, *The Advocate*;
Some lines by Richard Howard gave us hope.
A quiet hospital is infinite,
The polished, ice-white floors, the darkened halls
That lead to almost anywhere, to death
Or ghostly, lighted Coke machines. I call
To him one night, at home, asleep. His breath,
I dreamed, had filled my lungs—his lips, my lips
Had touched. I felt as though I'd touched a shrine.
Not disrespectfully, but in some lapse
Of concentration. In a mirror shines

The distant moon.

Michael Lassell is the current managing editor of *L.A. Style* magazine. His poetry has appeared in several periodicals, and he has published a collection, *Poems for Lost and Un-Lost Boys,* which won the Amelia Chapbook Award. In this poem Lassell uses an ingenious device to blunt the horror, tragedy and prejudice of dying with AIDS.

When discussing "How to watch your brother die" you might want to raise some of the following questions:

* What is the effect of Lassell's writing as if the poem were a script to be played out?
* In clinical situations, have you experienced conflicting feelings of love and hate as described in the poem?
* What do you think Lassell's attitude is toward the healthy brother?
* Have you been with caregivers who have had similar experiences to those of the healthy brother?
* How might a patient who is dying from AIDS respond to this poem?
* What issues does this poem raise that might be important to discuss in relation to your patient on the wards?

How to Watch Your Brother Die

When the call comes, be calm.
Say to your wife, "My brother is dying. I have to fly to California."
Try not to be shocked that he already looks like a cadaver.
Say to the young man sitting by your brother's side, "I'm his brother."
Try not to be shocked when the young man says, "I'm his lover. Thanks for coming."

Listen to the doctor with a steel face on.
Sign the necessary forms.
Tell the doctor you will take care of everything.
Wonder why doctors are so remote.

Watch the lover's eyes as they stare into
your brother's eyes as they stare into
space.
Wonder what they see there.
Remember the time he was jealous and
opened your eyebrow with a sharp stick.
Forgive him out loud
even if he can't understand you.
Realize the scar will be
all that's left of him.

Over coffee in the hospital cafeteria
say to the lover, "You're an extremely good-looking young man."
Hear him say,

"I'm sorry. I don't know what it means to be
the lover of another man."
Hear him say,
"It's just like a wife, only the commitment is
deeper because the odds against you are so much
greater."
Say nothing, but
take his hand like a brother's.

Drive to Mexico for unproven drugs that might
help him live longer.
Explain what they are to the border guard.
Fill with rage when he informs you,
"You can't bring those across."
Begin to grow loud.
Feel the lover's hand on your arm,
restraining you. See in the guard's eye
how much a man can hate another man.
Say to the lover, "How can you stand it?"
Hear him say, "You get used to it."
Think of one of your children getting used to
another man's hatred.

Call your wife on the telephone. Tell her,
"He hasn't much time.
I'll be home soon." Before you hang up say,
"How could anyone's commitment be deeper than
a husband and wife?" Hear her say,
"Please, I don't want to know all the details."

When he slips into an irrevocable coma
hold his lover in your arms while he sobs,
no longer strong. Wonder how much longer

Know you have nothing God could possibly want.
Curse God, but do not
abandon Him.

Stare at the face of the funeral director
when he tells you he will not
embalm the body for fear of
contamination. Let him see in your eyes
how much a man can hate another man.

Stand beside a casket covered in flowers,
white flowers. Say,
"Thank you for coming" to each of several hundred men
who file past in tears, some of them
holding hands. Know that your brother's life
was not what you imagined. Overhear two mourners say,
"I wonder who'll be next."

Arrange to take an early flight home.
His lover will drive you to the airport.
When your flight is announced say,
awkwardly, "If I can do anything, please
let me know." Do not flinch when he says,
"Forgive yourself for not wanting to know him
after he told you. He did."
Stop and let it soak in. Say,
"He forgave me, or he knew himself?"
"Both," the lover will say, not knowing what else
to do. Hold him like a brother while he
kisses you on the cheek. Think that
you haven't been kissed by a man since
your father died. Think,

"This is no moment not to be strong." Fly
first class and drink scotch. Stroke
your split eyebrow with a finger
and think of your brother alive. Smile
at the memory and think
how your children will feel in your arms,
warm and friendly and without challenge.

■ - Michael Lassell

Mark Doty "Fog"

Mark Doty, American poet and teacher, lives in Massachusetts and Vermont. He has published several collections; "Fog" was published in *My Alexandria* (1993). Marjorie Marks wrote in the LA Times Book Review, "*My Alexandria* is built around impermanence and doom, and though AIDS is a pervasive metaphor, the crystalline sensibility and breathtaking beauty of these poems is redemptive (on several levels) rather than depressive."

This is a challenging poem, and you should not feel that you need to understand it completely to present it. Issues and questions that you might want to raise when presenting "Fog" include:

* What might the flowers and garden represent?
* How do you interpret the memory of Frank?
* What might letters and characters represent in the poem?
* What is the medical professional's role in this poem? Why a "public health care worker?"
* What is the nature of spirituality for the narrator? For your patient?
* What topics and issues that are raised by the poem are relevant to the care of your patient on the wards?

Fog

The crested iris by the front gate waves
its blue flags three days, exactly,

then they vanish. The peony buds'
tight wrappings are edged crimson;

when they open, a little blood-color
will ruffle at the heart of the flounced,

unbelievable white. Three weeks after the test,
the vial filled from the crook

of my elbow, I'm seeing blood everywhere:
a casual nick from the garden shears,

a shaving cut and I feel the physical rush
of the welling up, the wine-fountain

dark as Siberian iris. The thin green porcelain
teacup, our homemade Ouija's planchette,

rocks and wobbles every night, spins
and spells. It seems a cloud of spirits

numerous as lilac panicles vie for occupancy—
children grabbing for the telephone,

happy to talk to someone who isn't dead yet?
Everyone wants to speak at once, or at least

these random words appear, incongruous
and exactly spelled: *energy, immunity, kiss.*

Then: *M. has immunity. W. has.*
And that was all. One character, Frank,

distinguishes himself: a boy who lived
in our house in the thirties, loved dogs

and gangster movies, longs for a body,
says he can watch us through the television,

asks us to stand before the screen
and kiss. *God in garden,* he says.

Sitting out on the back porch at twilight,
I'm almost convinced. In this geometry

of paths and raised beds, the green shadows
of delphinium, there's an unseen rustling:

some secret amplitude
seems to open in this orderly space.

Maybe because it contains so much dying,
all these tulip petals thinning

at the base until any wind takes them.
I doubt anyone else would see that, looking in,

and then I realize my garden has no outside, only *is*
subjectively. As blood is utterly without

an outside, can't be seen except out of context,
the wrong color in alien air, no longer itself.

Though it submits to test, two,
to be exact, each done three times,

though not for me, since at their first entry
into my disembodied blood

there was nothing at home there.
For you they entered the blood garden over

and over, like knocking at a door
because you know someone's home. Three times

the Elisa Test, three the Western Blot,
and then the incoherent message. We're

the public health care worker's
nine o'clock appointment,

she is a phantom hand who forms
the letters of your name, and the word

that begins with *P*. I'd lie out
and wait for the god if it weren't

so cold, the blue moon huge
and disruptive above the flowering crab's

foaming collapse. The spirits say *Fog*
when they can't speak clearly

and the letters collide; sometimes
for them there's nothing outside the mist

of their dying. Planchette,
peony, I would think of anything

not to say the word. Maybe the blood
in the flower is a god's. Kiss me,

in front of the screen, please,
the dead are watching.

They haven't had enough yet.
Every new bloom is falling apart.

I would say anything else
in the world, any other word.

– Mark Doty

Anthologies of poetry and medicine:

Jon Mukand, ed. Articulations: The Body and Illness in Poetry. University of Iowa Press. 1994.
This is a compilation of poems on medical themes by many poets. The poems are written, by the most part, by established authors, some of whom are also practicing physicians. These contemporary poems are recommended for their accessibility and diversity.

American poets who have written poetry that is relevant to medicine include:

William Carlos Williams. Williams was a pediatrician in Rutherford, New Jersey. He was also a poet who set out to create a specifically American poetics, based on rhythms and colorations of American speech, thought, and experience. Often drawing on his medical experiences in his poetry, Williams is the prototypical American physician-poet.

Sylvia Plath. Sylvia Plath struggled with mental illness throughout her life. She published several collections of poetry and an autobiographic book, The Bell Jar. Her work is intimately tied to her struggle with depression. She has also written poems that address suicide, insomnia, and life in the hospital, all of which are thematically relevant to clinical medicine.

Anne Sexton. Sexton began writing poetry at the suggestion of her therapist. Notable for its frankness and intimacy, Sexton's poetry often explores topics that are relevant to medicine including suicide, depression, insomnia, the hospital, and death and dying. Her collection of poetry is published by Houghton Mifflin Company.

Marilyn Hacker. Hacker is a contemporary American poet whose poetry often explores the nature of identity. After her experience with breast cancer, she wrote the provokative collection 'Cancer Winter' which can be found in her book Winter Numbers .

Beyond these well-known poets there are many other contemporary poets whose work is directly relevant to medicine. Poets in this category include ***Rika Lesser, Audry Lord, Eve Sedgwick, Alice Jones,*** and ***Forest Hamer***.

Poetry of AIDS:

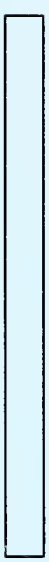
Rafael Campo. Possibly because he is a practicing physician himself, Campo's poetry is probably the most accessible poetry of AIDS for medical professionals. He is a Cuban-American internist in Boston and has published two collections of poetry The Other Man Was Me and What the Body Told. He has also published a collection of essays entitled The Poetry of Healing. Much of his work, both poetry and prose, concerns issues of identity within medical, latino, and gay cultures.

Thom Gunn. As poet and teacher living in San Francisco, Gunn has written eloquently of the nature and devastation of AIDS. His most pertinent collection in this respect is The Man with Night Sweats. Gunn's well regarded stature within the American literary community should not deter an inexperienced reader from approaching his very accessible work.

Paul Monette. Monette is a modern gay poet who has written extensively on AIDS. His most well-known work on this topic is a very complex series of elegies to his lover who died of AIDS. These elegies are collected in Love Alone: 18 Elegies for Rog a more recent collection of his poetry is entitled West of Yesterday, East of Summer. I do not recommend Monette as your first introduction to the poetry of the AIDS era, but he is a rewarding and challenging poet to explore.

Other poets who have eloquently of AIDS include ***David Bergman, Heather McHugh,*** and ***Mark Doty***. Anthologies of AIDS poetry include Poets for Life (two volumes) edited by Michael Klein and Unending Dialogue: Voices from an AIDS poetry workshop edited by Rachel Hadas. Klein, in Poets for Life, collected previously published poetry as well as works written specifically for his collection. The collection Unending Dialogue consists of poems written for an AIDS-poetry workshop.

Poetry on rounds



death and dying

Table of Contents

Poetry on Rounds:
Death and Dying

Pieter Cohen
Yale Medical School

How to approach your poem

I. Introduction

We will be spending 15 to 20 minutes of attending rounds discussing one poem in relation to a specific clinical situation on the wards. ***Don't panic*** — this discussion requires no previous knowledge, understanding, or comfort with poetry. Hopefully, poetry will provide a common ground to discuss issues relevant to clinical medicine that may not be easily discussed using the medical literature alone.

II. Choosing a poem

In this packet, you will find three or four poems, each with an introductory coversheet. You may choose one of the poems in this packet or bring in a different poem to discuss. You may select your poem for any reason, keeping your patient in mind. You might want to begin the discussion by explaining why you chose the poem. In addition, you might want to give the poem to other members of your team to read ahead of time.

III. Analyzing your poem

Reading, understanding, thinking and discussing poetry is in many ways completely different from the biomedical model we are accustomed to using in the hospital. On the wards, we use clinical knowledge to narrow down differential diagnoses to uncover the truth and find solutions to complex problems. In complex poetry, there are no correct answers and a single interpretation is not necessarily right nor wrong. In the language of poetry multiple meanings may exist simultaneously. We learn to live with uncertainty and ambiguity. A corollary of this is that there may not be simple conclusions to be drawn. As our personal experiences change, our understanding of a poem may change.

As you begin to read and think about the poem you selected, remember that your presentation will draw more from the connections you find between your poem, your patient and your personal experiences than your literary expertise. In other words, it will not be necessary to analyze your poem as if you were a literature graduate student.

Let your mind wander freely when you are thinking about the poem. There is *not a right answer* when understanding poetry. For each poem there may be many themes and interpretations. Assume that each word, phrase and sentence has multiple meanings. If readers have different points of view, they may all be correct. There are some interpretations that might be more convincing than others, but the goal of the discussion will be to provide a comfortable environment to share different points of view. If the poem suggests something to you, it is worthy of discussion. Ezra Pound has described poetry as "language charged with meaning to the utmost possible degree." Therefore, don't hold back in your interpretations and associations.

Here are some pointers to keep in mind when considering your poem: 1) read your poem; 2) take a deep breath; 3) reread your poem and think about it; 4) do not get hung-up on parts of the poem you do not understand—you do not need to understand everything about the poem.

Aspects of the poem you may want to consider include: 1) the content; 2) the themes (there usually will be several); 3) the narrator's perspective; 5) what issues, concerns, and perspectives does the poem raise in the context of your clinical scenario; 6) your emotional response to the poem and your emotional response to your patient.

Although it is not necessary, if you are so inclined you may wish to address some of the literary aspects of your poem. You may want to assess the tone (attitude of the author toward his or her subject), and the complexity, or lack-there-of, of the language (syntax, rhythm, word choice, meter, metaphors, analogies).

IV. Presenting your poem

The most important aspects of a successful presentation will be simply to have photocopied the poem for all members of the group, read the poem out loud at the onset, and provide an open and supportive environment for the discussion. The team might not know where to begin the discussion after you have read the poem aloud. Come prepared with some thoughts and comments. An introduction may be to simply begin by talking about what you liked, or disliked, in the poem and why you chose it.

An important part of the discussion will be connecting your poem back to your patient. Sometimes the clinical scenario will be strikingly similar in the poem and the connections will be obvious. However, most of the time the connections may not be very clear. In these cases, it might be easier to think of the poem as an analogy, metaphor, or allegory of your clinical situation. There are many other ways to connect the poem to the clinical situation: for example, you could consider the perspective in the poem and consider how that perspective may, or may not, be similar to your patient's. Another approach would be to consider the feelings, concerns and anxieties that reading this poem might evoke for the team with respect to this clinical situation, or how your patient might feel if he or she were to read the poem.

Above all, have fun with the experience. Remember that the style and format of the presentations are open to your own creativity and interests. Enjoy them!

Donald Hall "The ship pounding" and **Jane Kenyon "The sick wife"**

These two poems were written by husband and wife, both writers, as they stuggled with Kenyon's 15-month-long illness with leukemia. These two poems were first published together a year after Kenyon died at age 48 in 1995. Donald Hall wrote of the experience of caring for his wife, while Jane Kenyon described one poignant moment during the course of her illness. These poems were recently reprinted in Academic Medicine by Felice Aull, who teaches the literature of medicine at NYU's school of medicine. Aull writes,

> In envisioning the hospital as ship, Hall makes a powerful use of metaphor. It allows the poet to communicate both his outsider's impression of the strange world in which he finds himself day after day and his recognition that his wife's illness is irreversible...Jane Kenyon gives us only a brief inward glimpse of her illness, but it is extremely revealing. The most trivial activities of daily life have become unmanageable. Dependent and feeling out of place, she is not just sick, she is "sick at heart." Hall is the partner—caregiver; his poem is filled with movement, noise, and agitation. Kenyon is the weakened recipient of care; she sits immobilized, barely a person in her own right—"the sick wife."[1]

In addition to the thoughts above, some questions to keep in mind while reading and comparing the two poems:

* Why might have Hall choosen a ship as his metaphor for the hospital? Do you agree with Aull's interpretation above?
* How does Hall use a shift in verb tense in the middle of his poem to convey meaning?
* How does Hall describe changes in himself and his wife?
* Have you experienced similar personal or clinical situations?
* Are some of the issues that are raised in these two poems similar to issues that arise for your patient? For the caregivers of your patient?

[1] Aull, Felice. Medicine and the arts. Acad Med 1997. 72(3): 194-5.

The Ship Pounding

By Donald Hall

Each morning I made my way
among gangways, elevators,
and nurses' pods to Jane's room
to interrogate grave helpers
who had tended her all night
like the ship's massive engines
that kept its propellers turning.
Week after week, I sat by her bed
with black coffee and the *Globe*.
The passengers on this voyage
wore masks or cannulae
or dangled devices that dripped
chemicals into their wrists,
but I believed that the ship
travelled to a harbor
of breakfast, work, and love.
I wrote: "When the infusions
are infused entirely, bone
marrow restored and lymphoblasts
remitted, I will take my wife,
as bald as Michael Jordan,
home to our dog and day."
Months later these words turn up
among papers on my desk at home,
as I listen to hear Jane call
for help, or speak in delirium,
waiting to make the agitated
drive to Emergency again,
for re-admission to the huge
vessel that heaves water month
after month, without leaving
port, without moving a knot,
without arrival or destination,
its great engines pounding.

The Sick Wife

By Jane Kenyon

The sick wife stayed in the car
while he bought a few groceries.
Not yet fifty,
she had learned what it's like
not to be able to button a button.

It was the middle of the day—
and so only mothers with small children
or retired couples
stepped through the muddy parking lot.

Dry cleaning swung and gleamed on hangers
in the cars of the prosperous.
How easily they moved—
with such freedom,
even the old and relatively infirm.

The windows began to steam up.
The cars on either side of her
pulled away so briskly
that it made her sick at heart.

"The Sick Wife" also appears in *Otherwise: New and Selected Poems* (St. Paul, Minnesota: Graywolf Press, 1996).

Lisa Dittrich, staff editor of *Academic Medicine*, is the editor of "Medicine and the Arts." (Unsolicited submissions are welcome.)

Thom Gunn "Lament"

Thom Gunn was born and educated in Great Britian. In the 1950's he immigrated to the United States where he was professor at University of California at Berkeley until he resigned to devote more time to writing. Gunn has published a collection of poems about the AIDS epidemic, including "Lament," in *The Man with Night Sweats.*

Gunn's poetry is both accessible and challenging to new readers. The physician and critic Jack Coulehan has written, "Gunn's poems are lyrical, restrained, yet brutally honest. The work gains in power because of its lack of hysteria or exhibitionism. The use of meter and rhyme also contribute to the intensity." The physician and poet, Rafael Campo recalls his experience reading "Lament" to a patient: "we heard the respirator functioning in the plunging up-and-down iambics of 'Lament,' we nearly cried together."[1]

Some suggestions and questions to keep in mind when you're thinking about and discussing "Lament" including:

* What do you think of the friend's death?
* What is the narrator's experience of the transition from the hospital into the outdoors? Why is it "not enough like pain?"
* What issues of death and dying in the medical environment does the poem raise?
* What do you think about reading "Lament," or other poems, to a patient?
* What issues does this poem raise that might also be important to discuss in relation to your patient and his or her caregivers on the wards?

Note: Given that this is a slightly longer poem it would be very useful to encourage the rest of the team to read it in advance. When you present it you may want to select important, challenging, or moving sections to read aloud, if you don't think you'll have time to read the whole poem.

[1] Campo, Rafael. The Poetry of Healing. W.W.Norton & Co, New York. 1997. p.164.

Lament

ing was a difficult enterprise.
ty things took up your energies,
ll but clustering duties of the sick,
ıs the cough's dry rhetoric.
ours of waiting for pills, shot, X-ray
while you read novels two a day)
with a kind of clumsy stealth
d you from the habits of your health.
e still, courteous still, but tired and thin,
d to stay the man that you had been,
each symptom as a mere mishap
import. But then the spinal tap.
ıt a hard headache, and when night came
ou wake up from the same bad dream
lf-hour with the same short cry
outrage, before immediately
into the nightmare once again
f content but the drip of pain.
te followed: though the nightmare ceased,
ıgh grew thick and rich, its strength increased.
hts, and on the fifth we drove you down
mergency Room. That frown, that frown:
seen such rage in you before
they wheeled you through the swinging door.
knew, rightly, they conveyed you from
ormal pleasures of the sun's kingdom
onistic body basks within
s for granted – summer on the skin,
hout break, the moderate taste of tea

In a dry mouth. You had gone on from me
As if your body sought out martyrdom
In the far Canada of a hospital room.
Once there, you entered fully the distress
And long pale rigours of the wilderness.
A gust of morphine hid you. Back in sight
You breathed through a segmented tube, fat, white,
Jammed down your throat so that you could not speak.
  How thin the distance made you. In your cheek
One day, appeared the true shape of your bone
No longer padded. Still your mind, alone,
Explored this emptying intermediate
State for what holds and rests were hidden in it.
  You wrote us messages on a pad, amused
At one time that you had your nurse confused
Who, seeing you reconciled after four years
With your grey father, both of you in tears,
Asked if this was at last your 'special friend'
(The one you waited for until the end).
'She sings,' you wrote, 'a Philippine folk song
To wake me in the morning . . . It is long
And very pretty.' Grabbing at detail
To furnish this bare ledge toured by the gale,
On which you lay, bed restful as a knife,
You tried, tried hard, to make of it a life
Thick with the complicating circumstance
Your thoughts might fasten on. It had been chance
Always till now that had filled up the moment
With live specifics your hilarious comment
Discovered as it went along; and fed,
Laconic, quick, wherever it was led.
You improvised upon your own delight.
I think back to the scented summer night

We talked between our sleeping bags, below
A molten field of stars five years ago:
I was so tickled by your mind's light touch
I couldn't sleep, you made me laugh too much,
Though I was tired and begged you to leave off.

Now you were tired, and yet not tired enough
– Still hungry for the great world you were losing
Steadily in no season of your choosing –
And when at last the whole death was assured,
Drugs having failed, and when you had endured
Two weeks of an abominable constraint,
You faced it equably, without complaint,
Unwhimpering, but not at peace with it.
You'd lived as if your time was infinite:
You were not ready and not reconciled,
Feeling as uncompleted as a child
Till you had shown the world what you could do
In some ambitious role to be worked through,
A role your need for it had half-defined,
But never wholly, even in your mind.
You lacked the necessary ruthlessness,
The soaring meanness that pinpoints success.
We loved that lack of self-love, and your smile,
Rueful, at your own silliness.
Meanwhile,
Your lungs collapsed, and the machine, unstrained,
Did all your breathing now. Nothing remained
But death by drowning on an inland sea
Of your own fluids, which it seemed could be
Kindly forestalled by drugs. Both could and would:
Nothing was said, everything understood,
At least by us. Your own concerns were not

Long-term, precisely, when they gave the shot
– You made local arrangements to the bed
And pulled a pillow round beside your head.
  And so you slept, and died, your skin gone grey,
Achieving your completeness, in a way.

Outdoors next day, I was dizzy from a sense
Of being ejected with some violence
From vigil in a white and distant spot
Where I was numb, into this garden plot
Too warm, too close, and not enough like pain.
I was delivered into time again
– The variations that I live among
Where your long body too used to belong
And where the still bush is minutely active.
You never thought your body was attractive,
Though others did, and yet you trusted it
And must have loved its fickleness a bit
Since it was yours and gave you what it could,
Till near the end it let you down for good,
Its blood hospitable to those guests who
Took over by betraying it into
The greatest of its inconsistencies
This difficult, tedious, painful enterprise.

- Thom Gunn

Dylan Thomas "Do not go gentle into that good night"

Dylan Thomas (1914-1953) was a Welsh writer and poet who struggled with alcoholism throughout his life and died prematurely at age 39. Despite his short life Thomas impacted the literary community of his time. Thomas' poetry has been described for its overtly emotional impact and its insistence on the importance of sound and rhythm. Thomas published "Do Not Go Gentle..." in 1951 in which a son implores his elderly father to fight, rather than accept, death.

Some questions and ideas to keep in mind while reading and presenting the poem:

* How does the son try to convince the father to fight? How does he use images and language to make his point? Is he persuasive?
* Do you think this poem is comforting? To the son? To the father?
* The son seems to be adamant about his advice to his dying father. Have you been personally or professionally involved in similar situations? What issues does the son's perspective raise? Does the care of your patient raise similar issues?

DO NOT GO GENTLE INTO THAT GOOD NIGHT

Do not go gentle into that good night,
Old age should burn and rave at close of day;
Rage, rage against the dying of the light.

Though wise men at their end know dark is right,
Because their words had forked no lightning they
Do not go gentle into that good night.

Good men, the last wave by, crying how bright
Their frail deeds might have danced in a green bay,
Rage, rage against the dying of the night.

Wild men who caught and sang the sun in flight,
And learn, too late, they grieved it on its way,
Do not go gentle into that good night.

Grave men, near death, who see with blinding sight
Blind eyes could blaze like meteors and be gay,
Rage, rage against the dying of the light.

And you, father, there on the sad height,
Curse, bless, me now with your fierce tears, I pray.
Do not go gentle into that good night.
Rage, rage against the dying of the light.

—Dylan Thomas

Emily Dickinson (1830-1886) was a superb and unusual American poet. Although practically isolated from the literary society of her day, she wrote her poetry alone in her room in Amherst, Massachusetts. She corresponded with critics during her lifetime, but only a few of her poems were published before her death. Dickinson's succinct poems often combine single moments of intensity with exultation. She is a challenging poet to approach, in part, because she created her own rules of grammar. Today we might find it useful to read her frequent capitalizations and dashes as emphasis and musical breaks.

The scholar Thomas Johnson has written that Dickinson

> "knew that she could not pierce through to the unknowable, but she insisted on asking the questions. Her agonizing sense of ironic contrasts; of the the weight of suffering; of the human predicament in which man is mocked, destroyed, and beckoned to some incomprehensible repose; of the limits of reason, order, and justice in human as well as divine relationships: — this is the anguish of the Shakespeare of *King Lear*."[1]

The following are suggested questions to keep in mind while thinking about these two poems. Remember that you do not have to completely, or even incompletely, understand the poems to present them.

* Do you think that the poem beginning "Pain-has an Element of blank-" recreates in its intensity the experience of pain described?
* How does Dickinson describe death? Is it a comforting view of death? What might be the "formal feeling"?
* Can these challenging and absract poems be brought back to relate to personal experiences?
* Do these poems speak of aspects of medical care, healing, or curing?
* Does Dickinson's poetry offer a new perspective or insight when considered along with your patient? How might the insight and power of Dickinson's poetry be relevant to the clinical care of your patient?

---

[1] Dickinson, E., *Final Harvest: Emily Dickinson's Poems*. 1961, Boston: Little, Brown, & Company. p. xii.

269
(650)

Pain – has an Element of Blank –
It cannot recollect
When it begun – or if there were
A time when it was not –

It has no Future – but itself –
Its Infinite contain
Its Past – enlightened to perceive
New Periods – of Pain.

c. 1862 1890

- Emily Dickinson

122
(341)

After great pain, a formal feeling comes –
The Nerves sit ceremonious, like Tombs –
The stiff Heart questions was it He, that bore,
And Yesterday, or Centuries before?

The Feet, mechanical, go round –
Of Ground, or Air, or Ought –
A Wooden way
Regardless grown,
A Quartz contentment, like a stone –

This is the Hour of Lead –
Remembered, if outlived,
As Freezing persons, recollect the Snow –
First – Chill – then Stupor – then the letting go –

c. 1862 1929

- Emily Dickinson

Anthologies of poetry and medicine:

Jon Mukand, ed. Articulations: The Body and Illness in Poetry. University of Iowa Press. 1994.
This is a compilation of poems on medical themes by many poets. The poems are written, by the most part, by established authors, some of whom are also practicing physicians. These contemporary poems are recommended for their accessibility and diversity.

American poets who have written poetry that is relevant to medicine include:

William Carlos Williams. Williams was a pediatrician in Rutherford, New Jersey. He was also a poet who set out to create a specifically American poetics, based on rhythms and colorations of American speech, thought, and experience. Often drawing on his medical experiences in his poetry, Williams is the prototypical American physician-poet.

Sylvia Plath. Sylvia Plath struggled with mental illness throughout her life. She published several collections of poetry and an autobiographic book, The Bell Jar. Her work is intimately tied to her struggle with depression. She has also written poems that address suicide, insomnia, and life in the hospital, all of which are thematically relevant to clinical medicine.

Anne Sexton. Sexton began writing poetry at the suggestion of her therapist. Notable for its frankness and intimacy, Sexton's poetry often explores topics that are relevant to medicine including suicide, depression, insomnia, the hospital, and death and dying. Her collection of poetry is published by Houghton Mifflin Company.

Marilyn Hacker. Hacker is a contemporary American poet whose poetry often explores the nature of identity. After her experience with breast cancer, she wrote the provokative collection 'Cancer Winter' which can be found in her book Winter Numbers .

Beyond these well-known poets there are many other contemporary poets whose work is directly relevant to medicine. Poets in this category include ***Rika Lesser, Audry Lord, Eve Sedgwick, Alice Jones,*** and ***Forest Hamer***.

Poetry of AIDS:

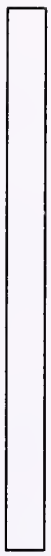
Rafael Campo. Possibly because he is a practicing physician himself, Campo's poetry is probably the most accessible poetry of AIDS for medical professionals. He is a Cuban-American internist in Boston and has published two collections of poetry The Other Man Was Me and What the Body Told. He has also published a collection of essays entitled The Poetry of Healing. Much of his work, both poetry and prose, concerns issues of identity within medical, latino, and gay cultures.

Thom Gunn. As poet and teacher living in San Francisco, Gunn has written eloquently of the nature and devastation of AIDS. His most pertinent collection in this respect is The Man with Night Sweats. Gunn's well regarded stature within the American literary community should not deter an inexperienced reader from approaching his very accessible work.

Paul Monette. Monette is a modern gay poet who has written extensively on AIDS. His most well-known work on this topic is a very complex series of elegies to his lover who died of AIDS. These elegies are collected in Love Alone: 18 Elegies for Rog a more recent collection of his poetry is entitled West of Yesterday, East of Summer. I do not recommend Monette as your first introduction to the poetry of the AIDS era, but he is a rewarding and challenging poet to explore.

Other poets who have eloquently of AIDS include ***David Bergman, Heather McHugh,*** and ***Mark Doty***. Anthologies of AIDS poetry include Poets for Life (two volumes) edited by Michael Klein and Unending Dialogue: Voices from an AIDS poetry workshop edited by Rachel Hadas. Klein, in Poets for Life, collected previously published poetry as well as works written specifically for his collection. The collection Unending Dialogue consists of poems written for an AIDS-poetry workshop.

poetry on rounds



refusal of medical therapy

Table of Contents

Poetry on Rounds:
Refusal of Medical Therapy

Pieter Cohen
Yale Medical School

How to approach your poem

I. Introduction

We will be spending 15 to 20 minutes of attending rounds discussing one poem in relation to a specific clinical situation on the wards. ***Don't panic*** — this discussion requires no previous knowledge, understanding, or comfort with poetry. Hopefully, poetry will provide a common ground to discuss issues relevant to clinical medicine that may not be easily discussed using the medical literature alone.

II. Choosing a poem

In this packet, you will find three or four poems, each with an introductory coversheet. You may choose one of the poems in this packet or bring in a different poem to discuss. You may select your poem for any reason, keeping your patient in mind. You might want to begin the discussion by explaining why you chose the poem. In addition, you might want to give the poem to other members of your team to read ahead of time.

III. Analyzing your poem

Reading, understanding, thinking and discussing poetry is in many ways completely different from the biomedical model we are accustomed to using in the hospital. On the wards, we use clinical knowledge to narrow down differential diagnoses to uncover the truth and find solutions to complex problems. In complex poetry, there are no correct answers and a single interpretation is neither necessarily right nor wrong. In the language of poetry multiple meanings may exist simultaneously. We learn to live with uncertainty and ambiguity. A corollary of this is that there may not be simple conclusions to be drawn. As our personal experiences change, our understanding of a poem may change.

As you begin to read and think about the poem you selected, remember that your presentation will draw more from the connections you find between your poem, your patient and your personal experiences than your literary expertise. In other words, it will not be necessary to analyze your poem as if you were a literature graduate student.

Let your mind wander freely when you are thinking about the poem. There is *not a right answer* when understanding poetry. For each poem there may be many themes and interpretations. Assume that each word, phrase and sentence has multiple meanings. If readers have different points of view, they may all be correct. There are some interpretations that might be more convincing than others, but the goal of the discussion will be to provide a comfortable environment to share different points of view. If the poem suggests something to you, it is worthy of discussion. Ezra Pound has described poetry as "language charged with meaning to the utmost possible degree." Therefore, don't hold back in your interpretations and associations.

Here are some pointers to keep in mind when considering your poem: 1) read your poem; 2) take a deep breath; 3) reread your poem and think about it; 4) do not get hung-up on parts of the poem you do not understand—you do not need to understand everything about the poem.

Aspects of the poem you may want to consider include: 1) the content; 2) the themes (there usually will be several); 3) the narrator's perspective; 5) what issues, concerns, and perspectives does the poem raise in the context of your clinical scenario; 6) your emotional response to the poem and your emotional response to your patient.

Although it is not necessary, if you are so inclined you may wish to address some of the literary aspects of your poem. You may want to assess the tone (attitude of the author toward his or her subject), and the complexity of the language (syntax, rhythm, word choice, meter, metaphors, analogies).

IV. Presenting your poem

The most important aspects of a successful presentation will be simply to have photocopied the poem for all members of the group, read the poem out loud at the onset, and provide an open and supportive environment for the discussion. The team might not know where to begin the discussion after you have read the poem aloud. Come prepared with some thoughts and comments. An introduction may be to simply begin by talking about what you liked, or disliked, in the poem and why you chose it.

An important part of the discussion will be connecting your poem back to your patient. Sometimes the clinical scenario will be strikingly similar in the poem and the connections will be obvious. However, most of the time the connections may not be very clear. In these cases, it might be easier to think of the poem as an analogy, metaphor, or allegory of your clinical situation. There are many other ways to connect the poem to the clinical situation: for example, you could consider the perspective in the poem and consider how that perspective may, or may not, be similar to your patient's. Another approach would be to consider the feelings, concerns and anxieties that reading this poem might evoke for the team with respect to this clinical situation, or how your patient might feel if he or she were to read the poem.

Above all, have fun with the experience. Remember that the style and format of the presentations are open to your own creativity and interests. Enjoy them!

Lisel Mueller "Monet refuses the operation"

After migrating from Germany in 1939, Lisel Mueller (1924-) has worked as a freelance writer, poet, reviewer and instructor of creative writing at Goddard College, Vermont.

In "Monet refuses the operation" which she based on the historical Claude Monet, Mueller explores one aspect of the painter's decision not to have an ophthalmic operation. Monet had visual problems since he was a young man and went on to develop cataracts. It has been suggested that his blurred vision contributed to his Impressionistic style. During Monet's lifetime he consulted several doctors to evaluate his vision and, after a long delay, Monet eventually underwent operations to remove his cataracts. Concerned that he might become blind, he ultimately refused further surgery.*

When presenting "Monet refuses the operation" you might find the following questions useful to raise:

* In the poem, how do the physicians describe Monet's changes in vision? How does Monet?
* Does Mueller present all the aspects of the decision that Monet probably took into account?
* Have you had similar clinical experiences when patients have refused medical therapy for personal or professional reasons?
* How is this poem, and the issues it raises, relevant to your current clinical situation?

* McLellan has recently discussed this poem and its relation to clinical medicine in the *Lancet* 1996; 348: 1640-41.

Monet refuses the operation

Doctor, you say there are no haloes
around the streetlights in Paris
and what I see is an aberration
caused by old age, an affliction.
I tell you it has taken me all my life
to arrive at the vision of gas lamps as angels,
to soften and blur and finally banish
the edges you regret I don't see,
to learn that the line I called the horizon
does not exist and sky and water,
so long apart, are the same state of being.
Fifty-four years before I could see
Rouen cathedral is built
of parallel shafts of sun,
and now you want to restore
my youthful errors: fixed
notions of top and bottom,
the illusion of three-dimensional space,
wisteria separate
from the bridge it covers.
What can I say to convince you
the Houses of Parliament dissolve
night after night to become
the fluid dream of the Thames?
I will not return to a universe
of objects that don't know each other,
as if islands were not the lost children
of one great continent. The world
is flux, and light becomes what it touches,
becomes water, lilies on water,
above and below water,
becomes lilac and mauve and yellow
and white and cerulean lamps,
small fists passing sunlight
so quickly to one another
that it would take long, streaming hair
inside my brush to catch it.
To paint the speed of light!
Our weighted shapes, these verticals,
burn to mix with air
and change our bones, skin, clothes
to gases. Doctor,
if only you could see
how heaven pulls earth into its arms
and how infinitely the heart expands
to claim this world, blue vapor without end.

Jack Coulehan "The man with stars inside"

Jack Coulehan is an American physician, writer and poet. As professor of medicine at SUNY-Stonybrook, Coulehan uses literature to teach clinical ethics. Coulehan recently used this poem to introduce a paper on the end-of-life decision making process [*Ann Int Med* 1997; 126:799-802]. Coulehan described his patient, Antonio, who was dying of lung cancer when he contracted pneumonia. After the decision had been made not to treat his pneumonia with antibiotics, Coulehan writes of Antonio's kissing his hand on the last day of his life. Coulehan also recalls the time spent in Antonio's room after his death talking with his daughters.

When discussing "The Man with Stars Inside" questions you may choose to pose to the team include:

* What might be the significance of the galaxy?
* To whom is pneumonia "a welcome friend"?
* What is the physician's responsibility in this fictitious situation?
* How does this situation relate to clinical situations you have experienced?
* How does the nature of the doctor-patient relationship play into this poem?
* If you are currently caring for someone who is making end-of-life decisions, how does this poem relate to your current clinical situation?

The Man with Stars Inside

Deep in this old man's chest
a shadow of pneumonia grows.
I watch Antonio shake
with a cough that traveled here
from the beginning of life.
As he pulls my hand to his lips
and kisses my hand,
Antonio tells me
for a man whose death
is gnawing at his spine,
pneumonia is a welcome friend,
a friend who reaches
deep between his ribs without a sound
and *puff!* a cloud begins to squeeze
so delicately
the great white image of his heart.

The shadow on his X-ray grows
each time Antonio moves
each time a nurse
smoothes lotion on his back
or puts a fleece between his limbs.
Each time he takes a sip of ice
and moist chest shakes with cough,
the shadow grows.
In that delicate shadow
is a cloud of gas

at the galaxy's center,
a cloud of cold stunned nuclei
beginning to spin,
spinning and shooting
a hundred thousand embryos of stars.
I listen to Antonio's chest
where stars crackle from the past
and hear the boom
of blue giants, newly caught,
and the snap of white dwarfs
coughing, spinning.
The second time
Antonio kisses my hand
I feel his dusky lips
reach out from everywhere in space.
I look at the place
his body was,
and see inside, the stars.

-Jack Coulehan

Maya Angelou "The Last Decision"

Maya Angelou, born in Missouri, grew up in Arkansas and California. In addition to her many scholarly and literary accomplishments, she has worked as a night-club singer in New York and edited the *African Review* in Ghana. She is currently professor of American studies at Wake Forest University, North Carolina. The strength of her lyrics lies in the combination of blues and gospel traditions with strong emotional and political insight. President Clinton asked her to read her poem "A rock, a river, a tree" at his inaugural ceremony.

You might chose to pose some of the following questions to the team when you present "The Last Decision":

* What types of ethical and moral issues does the narrator of the poem present for her caregivers?
* Does the poem reflect American values and views of the elderly? Views of end-of-life decisions?
* Have you been presented with similar situations on the wards? In your personal life?
* If you are currently caring for a patient facing end-of-life decisions, how does this poem's perspective compare to that on the wards? What issues are raised in the discussion of the poem that are relevant to care of dying patients on the wards?

The Last Decision

❧ MAYA ANGELOU

The print is too small, distressing me.
Wavering black things on the page.
Wriggling polliwogs all about.
I know it's my age.
I'll have to give up reading.

The food is too rich, revolting me.
I swallow it hot or force it down cold,
and wait all day as it sits in my throat.
Tired as I am, I know I've grown old.
I'll have to give up eating.

My children's concerns are tiring me.
They stand at my bed and move their lips,
and I cannot hear one single word.
I'd rather give up listening.

Life is too busy, wearying me.
Questions and answers and heavy thought.
I've subtracted and added and multiplied,
and all figuring has come to naught.
Today I'll give up living.

Anthologies of poetry and medicine:

Jon Mukand, ed. Articulations: The Body and Illness in Poetry. University of Iowa Press. 1994.
This is a compilation of poems on medical themes by many poets. The poems are written, by the most part, by established authors, some of whom are also practicing physicians. These contemporary poems are recommended for their accessibility and diversity.

American poets who have written poetry that is relevant to medicine include:

William Carlos Williams. Williams was a pediatrician in Rutherford, New Jersey. He was also a poet who set out to create a specifically American poetics, based on rhythms and colorations of American speeeh, thought, and experience. Often drawing on his medical experiences in his poetry, Williams is the prototypical American physician-poet.

Sylvia Plath. Sylvia Plath struggled with mental illness throughout her life. She publishcd several colleetions of poetry and an autobiographic book, The Bell Jar. Her work is intimately tied to her struggle with depression. She has also written poems that address suicide, insomnia, and life in the hospital, all of whieh are thematically relevant to clinical medicine.

Anne Sexton. Sexton began writing poetry at the suggestion of her therapist. Notable for its frankness and intimacy, Sexton's poetry often explores topics that are relevant to medicine including suicide, depression, insomnia, the hospital, and death and dying. Her collection of poetry is published by Houghton Mifflin Company.

Marilyn Hacker. Hacker is a contemporary American poet whose poetry often explores the nature of identity. After her experience with breast cancer, she wrote the provokative collection 'Cancer Winter' which can be found in her book Winter Numbers .

Beyond these well-known poets there are many other contemporary poets whose work is directly relevant to medicine. Poets in this category include ***Rika Lesser, Audry Lord, Eve Sedgwick, Alice Jones,*** and ***Forest Hamer***.

Poetry of AIDS:

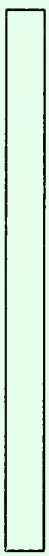
Rafael Campo. Possibly becausc he is a practicing physician himself, Campo's poetry is probably the most accessible poctry of AIDS for medical professionals. He is a Cuban-American internist in Boston and has published two collections of poetry The Other Man Was Me and What the Body Told. He has also published a collection of essays entitled The Poetry of Healing. Much of his work, both poetry and prose, concerns issues of identity within medical, latino, and gay cultures.

Thom Gunn. As poet and teacher living in San Francisco, Gunn has written eloquently of the nature and devastation of AIDS. His most pertinent collection in this respect is The Man with Night Sweats. Gunn's well regarded stature within the American literary community should not deter an inexperienced reader from approaching his very accessible work.

Paul Monette. Monette is a modern gay poet who has written extensively on AIDS. His most well-known work on this topic is a very complex series of elegies to his lover who died of AIDS. These elegies are collected in Love Alone: 18 Elegies for Rog a more recent collection of his poetry is entitled West of Yesterday, East of Summer. I do not recommend Monette as your first introduction to the poetry of the AIDS era, but he is a rewarding and challenging poet to explore.

Other poets who have eloquently of AIDS include ***David Bergman, Heather McHugh,*** and ***Mark Doty***. Anthologies of AIDS poetry include Poets for Life (two volumes) edited by Michael Klein and Unending Dialogue: Voices from an AIDS poetry workshop edited by Rachel Hadas. Klein, in Poets for Life, collected previously published poetry as well as works written specifically for his collection. The collection Unending Dialogue consists of poems written for an AIDS-poetry workshop.

Poetry on rounds



intractable pain

Table of Contents

Poetry on Rounds: Intractable Pain

Pieter Cohen
Yale Medical School

How to approach your poem

I. Introduction

We will be spending 15 to 20 minutes of attending rounds discussing one poem in relation to a specific clinical situation on the wards. ***Don't panic*** — this discussion requires no previous knowledge, understanding, or comfort with poetry. Hopefully, poetry will provide a common ground to discuss issues relevant to clinical medicine that may not be easily discussed using the medical literature alone.

II. Choosing a poem

In this packet, you will find three or four poems, each with an introductory coversheet. You may choose one of the poems in this packet or bring in a different poem to discuss. You may select your poem for any reason, keeping your patient in mind. You might want to begin the discussion by explaining why you chose the poem. In addition, you might want to give the poem to other members of your team to read ahead of time.

III. Analyzing your poem

Reading, understanding, thinking and discussing poetry is in many ways completely different from the biomedical model we are accustomed to using in the hospital. On the wards, we use clinical knowledge to narrow down differential diagnoses to uncover the truth and find solutions to complex problems. In complex poetry, there are no correct answers and a single interpretation is neither necessarily right nor wrong. In the language of poetry multiple meanings may exist simultaneously. We learn to live with uncertainty and ambiguity. A corollary of this is that there may not be simple conelusions to be drawn. As our personal experiences change, our understanding of a poem may change.

As you begin to read and think about the poem you selected, remember that your presentation will draw more from the connections you find between your poem, your patient and your personal experiences than your literary expertise. In other words, it will not be necessary to analyze your poem as if you were a literature graduate student.

Let your mind wander freely when you are thinking about the poem. There is *not a right answer* when understanding poetry. For each poem there may be many themes and interpretations. Assume that each word, phrase and sentence has multiple meanings. If readers have different points of view, they may all be correct. There are some interpretations that might be more convincing than others, but the goal of the discussion will be to provide a eomfortable environment to share different points of view. If the poem suggests something to you, it is worthy of discussion. Ezra Pound has described poetry as "language charged with meaning to the utmost possible degree." Therefore, don't hold baek in your interpretations and associations.

Here are some pointers to keep in mind when considering your poem: 1) read your poem; 2) take a deep breath; 3) reread your poem and think about it; 4) do not get hung-up on parts of the poem you do not understand—you do not need to understand everything about the poem.

Aspects of the poem you may want to consider include: 1) the content; 2) the themes (there usually will be several); 3) the narrator's perspective; 5) what issues, concerns, and perspectives does the poem raise in the context of your clinical scenario; 6) your emotional response to the poem and your emotional response to your patient.

Although it is not necessary, if you are so inclined you may wish to address some of the literary aspects of your poem. You may want to assess the tone (attitude of the author toward his or her subject), and the complexity of the language (syntax, rhythm, word choice, meter, metaphors, analogies).

IV. Presenting your poem

The most important aspects of a successful presentation will be simply to have photocopied the poem for all members of the group, read the poem out loud at the onset, and provide an open and supportive environment for the discussion. The team might not know where to begin the discussion after you have read the poem aloud. Come prepared with some thoughts and comments. An introduction may be to simply begin by talking about what you liked, or disliked, in the poem and why you chose it.

An important part of the discussion will be connecting your poem back to your patient. Sometimes the clinical scenario will be strikingly similar in the poem and the connections will be obvious. However, most of the time the connections may not be very clear. In these cases, it might be easier to think of the poem as an analogy, metaphor, or allegory of your clinical situation. There are many other ways to connect the poem to the clinical situation: for example, you could consider the perspective in the poem and consider how that perspective may, or may not, be similar to your patient's. Another approach would be to consider the feelings, concerns and anxieties that reading this poem might evoke for the team with respect to this clinical situation, or how your patient might feel if he or she were to read the poem.

Above all, have fun with the experience. Remember that the style and format of the presentations are open to your own creativity and interests. Enjoy them!

Molly Peacock was born in Buffalo, New York and is currently living and working in Manhattan. She has served as president of the Poetry Society of America and has published three collections of poetry. Her most recent volume, *Take Heart*, was published in 1988. Peacock's poetry often addresses the psychological dilemmas of contemporary life, frequently lightened by humor or ironic distance. In "Commands of Love," however, there is little humor or irony.

Some suggested questions to consider when reading and presenting "Commands of love,"

* How does Peacock describe the experience of pain and of caring for someone in pain?
* In Peacock's poem, do you think the narrator succeeded in alleviating some of the pain?
* How does this description compare with your personal or professional experiences?
* When Peacock writes that we "hover over those in pain" are you reminded of family and friends' reactions to pain? To physicians' responses to pain?
* What are some possible nonpharmacological approaches to your patient in pain?

COMMANDS OF LOVE

The tragedy of a face in pain
is how little you can do for it
because it is so closed. Having lain

outlined in knives, afraid to move,
it cannot move and therefore cannot love.
This is why we say it is a mask,

for the face is so frozen by hurt and fear
it is unable to ask for help.
You can do nothing but stay near.

This is why we hover over those in pain
doing things unasked for and unwanted,
hoping simply with our bodies to cover pain

as if to protect it. Better to go away.
But by asking for help pain is erased,
for the face opens to say what it has to say

and a beauty of concentration overcomes it.
The pain is saying outwardly what it is.
The help it asks for is what overcomes it.

Help me on with this dress.
Get me a glass of water.
Look, I've made a mess.

Both the face of pain and the face of the one
riveted to it in relief believe there's still
something to get, something to be done.

—*Molly Peacock*

Maxine Kumin "Pain: 1967"

Maxine Kumin, born in 1925, was friend to both of the poets Anne Sexton and Sylvia Plath. She has written novels, short stories, essays, and children's books as well as poetry. Kumin, who won the Pulitzer Prize in 1973, has taught at Columbia, Brandeis, and Princeton, and now lives in New Hampshire, where she is currently state poet laureate. The critic Ian Hamilton has written that "Kumin's...tone is steady, grounded, almost stoical in comparison....[to] contemporaries such as Plath and Sexton."

Some questions to keep in mind while reading "Pain: 1967" include:

* What do you make of Kumin comparing pain to sex? Do you find this analogy, or others in the poem, insightful?
* Do you think there is a lore or body of knowledge about pain? Are patients' kept from it? Are physicians kept from it?
* How does Kumin's patient compare to yours? What issues might the poem raise that are important to discuss in relation to your patient?
* What would be some useful approaches to either Kumin's fictitious patient or your patient in pain?

PAIN: 1967

The lore of it is something they keep from you.
As with sex, the mechanics are little rehearsed.
Not even among grown men and women the specifics—
yes he unbuttoned her, yes she was a good lay
but how? and in exactly what circumstance?

The nurses will not tell you. They baste and simmer
tools in the autoclave. The doctors whisper
Demerol into their stethoscopes. And the interns,
that volleyball team still challenging its acne,
can only pump up the bag full of blood pressure.

Meanwhile pain comes in dressed up like a spy.
A bearded spy wearing sneakers and murmuring *eat!*
Eat my quick poison. And of course I nibble the edges.
I eat my way to the center of his stem
because something inside it is secret.

At night rowing out to sea on drugs, rowing out
on my little oars, those carefully deployed spoons,
sometimes I think I catch a glimpse of that body
of knowledge. It is the fin of a flying fish.
It is a scrap of phosphorescent plankton
I would take hold of crying *wait!*
Thinking, *tell me.*

Understand that by this time the man next door
is calling *police police police*— his pain
burgles him. *Police*, that kind of father.
Understand that on the other side an old lady
in the thin voice of a music teacher is calling
yoohoo, help me, am I alone in this house?
She is dying with the shades drawn in a deserted villa.

Meanwhile I continue putting out to sea
on my little wooden ice cream spoons.
Although I am not a Catholic, the priest has laid
his hands upon me. He has put God into my pain.
Somewhere in my pineal gland He sits and gloats.

As for the lore, I have learned nothing to hand on.
I go out nightly past these particular needles
and these knives.

—*Maxine Kumin*

Jack Coulehan "The Knitted Glove"

Jack Coulehan is an American physician, writer and poet. As professor of medicine at SUNY-Stony brook, one of Coulehan interests is the use of literature in teaching clinical ethics. His poetry has been published widely.

Some issues and questions you might want to raise when discussing "The knitted glove" include:

* What's the significance of the glove?
* From a clinical perspective, how can we understand these events? Might there be more than one interpretation?
* What is the significance of the name that the narrator wants to wrestle to the ground? Does it have a name?
* Have you experienced similar clinical situations?
* For a patient with chronic pain, what issues does the poem raise? For the physician caring for the patient?

THE KNITTED GLOVE

You come into my office wearing a blue
knitted glove with a ribbon at the wrist.
You remove the glove slowly, painfully,
and dump out the contents, a worthless hand.
What a specimen! It looks much like a regular hand,
warm, pliable, soft, you can move the fingers.

If it's not one thing, it's another.
Last month the fire in your hips had you down
or up mincing across the room with a cane.
When I ask about the hips today, you pass it off
so I can't tell if only the pain
or the memory is gone. The knitted hand
is the long and short of it, pain doesn't exist
in the past any more than this morning does.

This thing, the name for your solitary days,
for the hips, the hand, for the walk of your eyes
away from mine, this thing is coyote, a trickster.
I want to call, "Come out, you son of a dog!"
and wrestle that name to the ground for you,
I want to take its neck between my hands.
But in this world I don't know how to find
the bastard, so we sit. We talk about the pain.

– Jack Coulehan

Emily Dickinson (1830-1886) was a superb and unusual American poet. Although practically isolated from the literary society of her day, she wrote her poetry alone in her room in Amherst, Massachusetts. She corresponded with critics during her lifetime, but only a few of her poems were published before her death. Dickinson's succinct poems often combine single moments of intensity with exultation. She is a challenging poet to approach, in part, because she created her own rules of grammar. Today we might find it useful to read her frequent capitalizations and dashes as emphasis and musical breaks.

The scholar Thomas Johnson has written that Dickinson

> "knew that she could not pierce through to the unknowable, but she insisted on asking the questions. Her agonizing sense of ironic contrasts; of the the weight of suffering; of the human predicament in which man is mocked, destroyed, and beckoned to some incomprehensible repose; of the limits of reason, order, and justice in human as well as divine relationships: — this is the anguish of the Shakespeare of *King Lear*."[1]

The following are suggested questions to keep in mind while thinking about these two poems. Remember that you do not have to completely, or even incompletely, understand the poems to present them.

* Do you think that the poem beginning "Pain-has an Element of blank-" recreates in its intensity the experience of pain described?
* How does Dickinson describe death? Is it a comforting view of death? What might be the "formal feeling"?
* Can these challenging and absract poems be brought back to relate to personal experiences?
* Do these poems speak of aspects of medical care, healing, or curing?
* Does Dickinson's poetry offer a new perspective or insight when considered along with your patient? How might the insight and power of Dickinson's poetry be relevant to the clinical care of your patient?

---

1 Dickinson, E., *Final Harvest: Emily Dickinson's Poems*. 1961, Boston: Little, Brown, & Company. p. xii.

269
(650)

Pain – has an Element of Blank –
It cannot recollect
When it begun – or if there were
A time when it was not –

It has no Future – but itself –
Its Infinite contain
Its Past – enlightened to perceive
New Periods – of Pain.

c. 1862 1890

– Emily Dickinson

122
(341)

After great pain, a formal feeling comes –
The Nerves sit ceremonious, like Tombs –
The stiff Heart questions was it He, that bore,
And Yesterday, or Centuries before?

The Feet, mechanical, go round –
Of Ground, or Air, or Ought –
A Wooden way
Regardless grown,
A Quartz contentment, like a stone –

This is the Hour of Lead –
Remembered, if outlived,
As Freezing persons, recollect the Snow –
First – Chill – then Stupor – then the letting go –

c. 1862 1929

– Emily Dickinson

Anthologies of poetry and medicine:

Jon Mukand, ed. Articulations: The Body and Illness in Poetry. University of Iowa Press. 1994.
This is a compilation of poems on medical themes by many poets. The poems are written, by the most part, by established authors, some of whom are also practicing physicians. These contemporary poems are recommended for their accessibility and diversity.

American poets who have written poetry that is relevant to medicine include:

William Carlos Williams. Williams was a pediatrician in Rutherford, New Jersey. He was also a poet who set out to create a specifically American poetics, based on rhythms and colorations of American speech, thought, and experience. Often drawing on his medical experiences in his poetry, Williams is the prototypical American physician-poet.

Sylvia Plath. Sylvia Plath struggled with mental illness throughout her life. She published several collections of poetry and an autobiographic book, The Bell Jar. Her work is intimately tied to her struggle with depression. She has also written poems that address suicide, insomnia, and life in the hospital, all of which are thematically relevant to clinical medicine.

Anne Sexton. Sexton began writing poetry at the suggestion of her therapist. Notable for its frankness and intimacy, Sexton's poetry often explores topics that are relevant to medicine including suicide, depression, insomnia, the hospital, and death and dying. Her collection of poetry is published by Houghton Mifflin Company.

Marilyn Hacker. Hacker is a contemporary American poet whose poetry often explores the nature of identity. After her experience with breast cancer, she wrote the provokative collection 'Cancer Winter' which can be found in her book Winter Numbers .

Beyond these well-known poets there are many other contemporary poets whose work is directly relevant to medicine. Poets in this category include ***Rika Lesser, Audry Lord, Eve Sedgwick, Alice Jones,*** and ***Forest Hamer***.

Poetry of AIDS:

Rafael Campo. Possibly because he is a practicing physician himself, Campo's poetry is probably the most accessible poetry of AIDS for medical professionals. He is a Cuban-American internist in Boston and has published two collections of poetry The Other Man Was Me and What the Body Told. He has also published a collection of essays entitled The Poetry of Healing. Much of his work, both poetry and prose, concerns issues of identity within medical, latino, and gay cultures.

Thom Gunn. As poet and teacher living in San Francisco, Gunn has written eloquently of the nature and devastation of AIDS. His most pertinent collection in this respect is The Man with Night Sweats. Gunn's well regarded stature within the American literary community should not deter an inexperienced reader from approaching his very accessible work.

Paul Monette. Monette is a modern gay poet who has written extensively on AIDS. His most well-known work on this topic is a very complex series of elegies to his lover who died of AIDS. These elegies are collected in Love Alone: 18 Elegies for Rog a more recent collection of his poetry is entitled West of Yesterday, East of Summer. I do not recommend Monette as your first introduction to the poetry of the AIDS era, but he is a rewarding and challenging poet to explore.

Other poets who have eloquently of AIDS include ***David Bergman, Heather McHugh,*** and ***Mark Doty***. Anthologies of AIDS poetry include Poets for Life (two volumes) edited by Michael Klein and Unending Dialogue: Voices from an AIDS poetry workshop edited by Rachel Hadas. Klein, in Poets for Life, collected previously published poetry as well as works written specifically for his collection. The collection Unending Dialogue consists of poems written for an AIDS-poetry workshop.

Poetry on rounds

addiction

Table of Contents

Poetry on Rounds: Addiction

Pieter Cohen
Yale Medical School

How to approach your poem

I. Introduction

We will be spending 15 to 20 minutes of attending rounds discussing one poem in relation to a specific clinical situation on the wards. ***Don't panic*** — this discussion requires no previous knowledge, understanding, or comfort with poetry. Hopefully, poetry will provide a common ground to discuss issues relevant to clinical medicine that may not be easily discussed using the medical literature alone.

II. Choosing a poem

In this packet, you will find three or four poems, each with an introductory coversheet. You may choose one of the poems in this packet or bring in a different poem to discuss. You may select your poem for any reason, keeping your patient in mind. You might want to begin the discussion by explaining why you chose the poem. In addition, you might want to give the poem to other members of your team to read ahead of time.

III. Analyzing your poem

Reading, understanding, thinking and discussing poetry is in many ways completely different from the biomedical model we are accustomed to using in the hospital. On the wards, we use clinical knowledge to narrow down differential diagnoses to uncover the truth and find solutions to complex problems. In complex poetry, there are no correct answers and a single interpretation is neither necessarily right nor wrong. In the language of poetry multiple meanings may exist simultaneously. We learn to live with uncertainty and ambiguity. A corollary of this is that there may not be simple conclusions to be drawn. As our personal experiences change, our understanding of a poem may change.

As you begin to read and think about the poem you selected, remember that your presentation will draw more from the connections you find between your poem, your patient and your personal experiences than your literary expertise. In other words, it will not be necessary to analyze your poem as if you were a literature graduate student.

Let your mind wander freely when you are thinking about the poem. There is *not a right answer* when understanding poetry. For each poem there may be many themes and interpretations. Assume that each word, phrase and sentence has multiple meanings. If readers have different points of view, they may all be correct. There are some interpretations that might be more convincing than others, but the goal of the discussion will be to provide a comfortable environment to share different points of view. If the poem suggests something to you, it is worthy of discussion. Ezra Pound has described poetry as "language charged with meaning to the utmost possible degree." Therefore, don't hold back in your interpretations and associations.

Here are some pointers to keep in mind when considering your poem: 1) read your poem; 2) take a deep breath; 3) reread your poem and think about it; 4) do not get hung-up on parts of the poem you do not understand—you do not need to understand everything about the poem.

Aspects of the poem you may want to consider include: 1) the content; 2) the themes (there usually will be several); 3) the narrator's perspective; 5) what issues, concerns, and perspectives does the poem raise in the context of your clinical scenario; 6) your emotional response to the poem and your emotional response to your patient.

Although it is not necessary, if you are so inclined you may wish to address some of the literary aspects of your poem. You may want to assess the tone (attitude of the author toward his or her subject), and the complexity of the language (syntax, rhythm, word choice, meter, metaphors, analogies).

IV. Presenting your poem

The most important aspects of a successful presentation will be simply to have photocopied the poem for all members of the group, read the poem out loud at the onset, and provide an open and supportive environment for the discussion. The team might not know where to begin the discussion after you have read the poem aloud. Come prepared with some thoughts and comments. An introduction may be to simply begin by talking about what you liked, or disliked, in the poem and why you chose it.

An important part of the discussion will be connecting your poem back to your patient. Sometimes the clinical scenario will be strikingly similar in the poem and the connections will be obvious. However, most of the time the connections may not be very clear. In these cases, it might be easier to think of the poem as an analogy, metaphor, or allegory of your clinical situation. There are many other ways to connect the poem to the clinical situation: for example, you could consider the perspective in the poem and consider how that perspective may, or may not, be similar to your patient's. Another approach would be to consider the feelings, concerns and anxieties that reading this poem might evoke for the team with respect to this clinical situation, or how your patient might feel if he or she were to read the poem.

Above all, have fun with the experience. Remember that the style and format of the presentations are open to your own creativity and interests. Enjoy them!

Illness and poetry were always intertwined in Anne Sexton's life and work. Sexton's psychiatrist first suggested she use poetry as therapy. What began as therapeutic poetry would later propel Sexton, who never graduated from college, to be elected a Fellow of the Royal Society of Literature in Great Britain, win a Pulitzer Prize in poetry for *Live or Die* (1967), and become a professor of creative writing at Boston University. However, her psychiatric illnesses continued to haunt her throughout her literary career.

Sexton often writes openly about her personal experiences in her poetry. She had attempted suicide many times in her life before the attempt in 1974 that took her life. Sexton's friend and fellow poet Maxine Kumin has written,

> "I am convinced that poetry kept Anne alive for the eighteen years of her creative endeavors. When everything else soured; when a succession of therapists deserted her for whatever good, poor, or personal reasons; when intimates lost interest or could not fulfill all the roles they were asked to play; when a series of catastrophes and physical illnesses assaulted her, the making of poems remained her one constant."[1]

The following are questions to keep in mind when presenting and reading "The Addict:"

* What is the narrator's perspective on her addiction?
* What might Sexton mean in the line begining with "I'm a little buttercup..." and why does she chose the images that she does?
* Although Sexton describes addiction to sleeping medications, how applicable is her poem to other types of addictions?
* The narrator is very insightful about her addiction Have you cared for patients who have spoken about the nature of their addiction?
* Does personal meaning and insight into one's illness have a place in clinical care?
* If you are currently caring for someone with an addiction, does this poem raise issues that might also be useful to raise in the context of caring for your patient?

[1] Kumin, Maxine. "How it was" in Anne Sexton: The Complete Poems. Houghton Mifflin Co. Boston. 1981. p.xxiii.

THE ADDICT

Sleepmonger,
deathmonger,
with capsules in my palms each night,
eight at a time from sweet pharmaceutical bottles
I make arrangements for a pint-sized journey.
I'm the queen of this condition.
I'm an expert on making the trip
and now they say I'm an addict.
Now they ask why.
Why!

Don't they know
That I promised to die!
I'm keeping in practice.
I'm merely staying in shape.
The pills are a mother, but better,
every color and as good as sour balls.
I'm on a diet from death.

Yes, I admit
it has gotten to be a bit of a habit—
blows eight at a time, socked in the eye,
hauled away by the pink, the orange,
the green and the white goodnights.
I'm becoming something of a chemical
mixture.
That's it!

My supply
of tablets
has got to last for years and years.
I like them more than I like me.
Stubborn as hell, they won't let me go.
It's a kind of marriage.
It's a kind of war
where I plant bombs inside
of myself.

Yes
I try
to kill myself in small amounts,
an innocuous occupation.
Actually I'm hung up on it.
But remember I don't make too much noise.
And frankly no one has to lug me out
and I don't stand there in my winding sheet.
I'm a little buttercup in my yellow nightie
eating my eight loaves in a row
and in a certain order as in
the laying on of hands
or the black sacrament.

It's a ceremony
but like any other sport
it's full of rules.
It's like a musical tennis match where
my mouth keeps catching the ball.
Then I lie on my altar
elevated by the eight chemical kisses.

What a lay me down this is
with two pink, two orange,
two green, two white goodnights.
Fee-fi-fo-fum—
Now I'm borrowed.
Now I'm numb.

—*Anne Sexton*

Langston Hughes "Junior addict"

Langston Hughes (1902-67) might have been the first American black to make his living as a writer. His talents ranged from poetry to autobiography to libretti for musicals and opera. When it was quite dangerous to do so, he was the first black American to write civil-rights protest poetry. Hughes succeeded in bringing the African-American experience and musical traditions into the American literary cannon. Although "Junior Addict" takes on a very contemporary theme, Hughes died in 1967.

Suggested questions to consider when reading and presenting "Junior Addict:"

* What do you think Hughes is suggesting about the connection between the young addict and Africa? What are our current perceptions of race and addition?
* Does Hughes offer any solutions or hope in this poem for the young addict?
* How does this addict compare to patients that you have cared for?
* What types of feelings do the addicts that Hughes describes raise for their caregivers, both family and professionals? Does this influence medical care?
* Are there other issues that this poem raises that might be important to raise in the care of your patient?

Junior Addict

LANGSTON HUGHES

The little boy
who sticks a needle in his arm
and seeks an out in other worldly dreams,
who seeks an out in eyes that droop
and ears that close to Harlem screams,
cannot know, of course,
(and has no way to understand)
a sunrise that he cannot see
beginning in some other land—
but destined sure to flood—and soon—
the very room in which he leaves
his needle and his spoon,
the very room in which today the air
is heavy with the drug
of his despair.

(Yet little can
tomorrow's sunshine give
to one who will not live.)

Quick, sunrise, come—
Before the mushroom bomb
Pollutes his stinking air
With better death
Than is his living here
With viler drugs
Than bring today's release
In poison from the fallout
Of our peace.

"It's easier to get dope
than it is to get a job."

Yes, easier to get dope
than to get a job—

daytime or nightime job,
teen-age, pre-draft,
pre-lifetime job.

Quick, sunrise, come!
Sunrise out of Africa,
Quick, come!
Sunrise, please come!
Come! Come!

John Stone "Confabulation"

John Stone, born in 1936, is an American physician, poet and essayist. As well as having published three collections of poetry and a collection of essays (*In the Country of Hearts*), he is professor of medicine, associate dean, and director of admissions at Emory University School of Medicine. He often describes his patients or the physician-patient encounter in his poetry.

Some questions you might want to raise when discussing "Confabulation" include:

* What takes place in the poem? Who is Loretta?
* Do you think Stone has captured the essence of confabulation in his poem?
* What types of emotions does a patient like the one in "Confabulation" raise for his caregivers? Have you cared for similar patients?
* If Loretta is a family member, what are some of the challenges she faces? What is the medical profession's role?

CONFABULATION

Striding up to his bed, you
know the right questions.
Old with alcohol, yellow
as a lemon, he wrinkles

for a cigarette. He
will lie to you at a moment's
confusion, going along with you

to cover the fact that he can't
remember yesterday.

Do you remember me?

Sure I remember you.

We met in the bar at 8th
and Jackson.

Yeah, sure.

The redhead: you remember her.

Yeah, I remember.

What was her name—started with
an L . . .

Loretta? Laura?

Loretta. That's it. What a
woman. You're a lucky man to
know Loretta.

I know. I know Loretta. I'm a lucky man.

And Loretta is a lucky woman.

—John Stone

Anthologies of poetry and medicine:

Jon Mukand, ed. Articulations: The Body and Illness in Poetry. University of Iowa Press. 1994.
This is a compilation of poems on medical themes by many poets. The poems are written, by the most part, by established authors, some of whom are also practicing physicians. These contemporary poems are recommended for their accessibility and diversity.

American poets who have written poetry that is relevant to medicine include:

William Carlos Williams. Williams was a pediatrician in Rutherford, New Jersey. He was also a poet who set out to create a specifically American poetics, based on rhythms and colorations of American speech, thought, and experience. Often drawing on his medical experiences in his poetry, Williams is the prototypical American physician-poet.

Sylvia Plath. Sylvia Plath struggled with mental illness throughout her life. She published several collections of poetry and an autobiographic book, The Bell Jar. Her work is intimately tied to her struggle with depression. She has also written poems that address suicide, insomnia, and life in the hospital, all of which are thematically relevant to clinical medicine.

Anne Sexton. Sexton began writing poetry at the suggestion of her therapist. Notable for its frankness and intimacy, Sexton's poetry often explores topics that are relevant to medicine including suicide, depression, insomnia, the hospital, and death and dying. Her collection of poetry is published by Houghton Mifflin Company.

Marilyn Hacker. Hacker is a contemporary American poet whose poetry often explores the nature of identity. After her experience with breast cancer, she wrote the provokative collection 'Cancer Winter' which can be found in her book Winter Numbers .

Beyond these well-known poets there are many other contemporary poets whose work is directly relevant to medicine. Poets in this category include ***Rika Lesser, Audry Lord, Eve Sedgwick, Alice Jones,*** and ***Forest Hamer***.

Poetry of AIDS:

Rafael Campo. Possibly because he is a practicing physician himself, Campo's poetry is probably the most accessible poetry of AIDS for medical professionals. He is a Cuban-American internist in Boston and has published two collections of poetry The Other Man Was Me and What the Body Told. He has also published a collection of essays entitled The Poetry of Healing. Much of his work, both poetry and prose, concerns issues of identity within medical, latino, and gay cultures.

Thom Gunn. As poet and teacher living in San Francisco, Gunn has written eloquently of the nature and devastation of AIDS. His most pertinent collection in this respect is The Man with Night Sweats. Gunn's well regarded stature within the American literary community should not deter an inexperienced reader from approaching his very accessible work.

Paul Monette. Monette is a modern gay poet who has written extensively on AIDS. His most well-known work on this topic is a very complex series of elegies to his lover who died of AIDS. These elegies are collected in Love Alone: 18 Elegies for Rog a more recent collection of his poetry is entitled West of Yesterday, East of Summer. I do not recommend Monette as your first introduction to the poetry of the AIDS era, but he is a rewarding and challenging poet to explore.

Other poets who have eloquently of AIDS include ***David Bergman, Heather McHugh,*** and ***Mark Doty***. Anthologies of AIDS poetry include Poets for Life (two volumes) edited by Michael Klein and Unending Dialogue: Voices from an AIDS poetry workshop edited by Rachel Hadas. Klein, in Poets for Life, collected previously published poetry as well as works written specifically for his collection. The collection Unending Dialogue consists of poems written for an AIDS-poetry workshop.

Poetry on rounds

adjusting to illness

Table of Contents

Poetry on Rounds:
Adjusting to Illness

Pieter Cohen
Yale Medical School

How to approach your poem

I. Introduction

We will be spending 15 to 20 minutes of attending rounds discussing one poem in relation to a specific clinical situation on the wards. ***Don't panic*** — this discussion requires no previous knowledge, understanding, or comfort with poetry. Hopefully, poetry will provide a common ground to discuss issues relevant to clinical medicine that may not be easily discussed using the medical literature alone.

II. Choosing a poem

In this packet, you will find three or four poems, each with an introductory coversheet. You may choose one of the poems in this packet or bring in a different poem to discuss. You may select your poem for any reason, keeping your patient in mind. You might want to begin the discussion by explaining why you chose the poem. In addition, you might want to give the poem to other members of your team to read ahead of time.

III. Analyzing your poem

Reading, understanding, thinking and discussing poetry is in many ways completely different from the biomedical model we are accustomed to using in the hospital. On the wards, we use clinical knowledge to narrow down differential diagnoses to uncover the truth and find solutions to complex problems. In complex poetry, there are no correct answers and a single interpretation is neither necessarily right nor wrong. In the language of poetry multiple meanings may exist simultaneously. We learn to live with uncertainty and ambiguity. A corollary of this is that there may not be simple conclusions to be drawn. As our personal experiences change, our understanding of a poem may change.

As you begin to read and think about the poem you selected, remember that your presentation will draw more from the connections you find between your poem, your patient and your personal experiences than your literary expertise. In other words, it will not be necessary to analyze your poem as if you were a literature graduate student.

Let your mind wander freely when you are thinking about the poem. There is *not a right answer* when understanding poetry. For each poem there may be many themes and interpretations. Assume that each word, phrase and sentence has multiple meanings. If readers have different points of view, they may all be correct. There are some interpretations that might be more convincing than others, but the goal of the discussion will be to provide a comfortable environment to share different points of view. If the poem suggests something to you, it is worthy of discussion. Ezra Pound has described poetry as "language charged with meaning to the utmost possible degree." Therefore, don't hold back in your interpretations and associations.

Here are some pointers to keep in mind when considering your poem: 1) read your poem; 2) take a deep breath; 3) reread your poem and think about it; 4) do not get hung-up on parts of the poem you do not understand—you do not need to understand everything about the poem.

Aspects of the poem you may want to consider include: 1) the content; 2) the themes (there usually will be several); 3) the narrator's perspective; 5) what issues, concerns, and perspectives does the poem raise in the context of your clinical scenario; 6) your emotional response to the poem and your emotional response to your patient.

Although it is not necessary, if you are so inclined you may wish to address some of the literary aspects of your poem. You may want to assess the tone (attitude of the author toward his or her subject), and the complexity of the language (syntax, rhythm, word choice, meter, metaphors, analogies).

IV. Presenting your poem

The most important aspects of a successful presentation will be simply to have photocopied the poem for all members of the group, read the poem out loud at the onset, and provide an open and supportive environment for the discussion. The team might not know where to begin the discussion after you have read the poem aloud. Come prepared with some thoughts and comments. An introduction may be to simply begin by talking about what you liked, or disliked, in the poem and why you chose it.

An important part of the discussion will be connecting your poem back to your patient. Sometimes the clinical scenario will be strikingly similar in the poem and the connections will be obvious. However, most of the time the connections may not be very clear. In these cases, it might be easier to think of the poem as an analogy, metaphor, or allegory of your clinical situation. There are many other ways to connect the poem to the clinical situation: for example, you could consider the perspective in the poem and consider how that perspective may, or may not, be similar to your patient's. Another approach would be to consider the feelings, concerns and anxieties that reading this poem might evoke for the team with respect to this clinical situation, or how your patient might feel if he or she were to read the poem.

Above all, have fun with the experience. Remember that the style and format of the presentations are open to your own creativity and interests. Enjoy them!

Rafael Campo attended Amherst College in Massachusetts. After graduating from Harvard medical school, he completed his residency in Internal Medicine at UCSF and moved to Boston as faculty at Beth Israel Hospital. He has published two collections of poetry *The Other Man Was Me* and *What the Body Told* and one collection of essays. As a Cuban-American and gay man, Campo often deals with issues of sexual identity and cultural identity. As a gay physician in the 1990's, he explores the patient-physician relationship in the era of AIDS.

Possible questions and suggestions to think about while reading "Lost in the Hospital" include:

* How does Campo use language to make his hospital visit so vivid?
* What might be the significance of the friend's touch and the choice of "keys?"
* What does "wistful" mean in this context? Why are the patients "true?"
* What does the narrator mean by "I'm lost" in the last line?
* What issues does this poem raise for care-givers?
* Are issues raised by Campo's poem similar to issues involving the care of your patient?

Lost in the Hospital

It's not that I don't like the hospital.
Those small bouquets of flowers, pert and brave.
The smell of antiseptic cleansers.
The ill, so wistful in their rooms, so true.
My friend, the one who's dying, took me out
To where the patients go to smoke, IV's
And oxygen in tanks attached to them—
A tiny patio for skeletons. We shared
A cigarette, which was delicious but
Too brief. I held his hand; it felt
Like someone's keys. How beautiful it was,
The sunlight pointing down at us, as if
We were important, full of life, unbound.
I wandered for a moment where his ribs
Had made a space for me, and there, beside
The thundering waterfall of his heart,
I rubbed my eyes and thought, "I'm lost."

-Rafael Campo

After attending Smith College and Cambridge University, Sylvia Plath studied poetry with the American poet Robert Lowell. Plath's life was a literary one in which she lived and worked with many of the literary luminaries of her time. As well as being talented, she was also very disturbed, a problem which colored her troubled autobiography, *The Bell Jar*, which was published just a few years before she committed suicide in 1963.

In March of 1961, Plath wrote "Tulips" after spending a week in the hospital for surgery.

Some possible starting points when discussing "Tulips" might be:

* What are your favorite images in the poem?
* How are the tulips described? With what are they compared? What might they represent?
* What might the images of water represent? The sea? The river?
* Do you think there a suggestion of mental illness in this poem?
* What does this tell us about the hospital experience?
* How might this poem help shed light on your patient's situation?

Tulips

The tulips are too excitable, it is winter here.
Look how white everything is, how quiet, how snowed-in.
I am learning peacefulness, lying by myself quietly
As the light lies on these white walls, this bed, these hands.
I am nobody; I have nothing to do with explosions.
I have given my name and my day-clothes up to the nurses
And my history to the anesthetist and my body to surgeons.

They have propped my head between the pillow and the sheet-cuff
Like an eye between two white lids that will not shut.
Stupid pupil, it has to take everything in.
The nurses pass and pass, they are no trouble,
They pass the way gulls pass inland in their white caps,
Doing things with their hands, one just the same as another,
So it is impossible to tell how many there are.

My body is a pebble to them, they tend it as water
Tends to the pebbles it must run over, smoothing them gently.
They bring me numbness in their bright needles, they bring me sleep.
Now I have lost myself I am sick of baggage——
My patent leather overnight case like a black pillbox,
My husband and child smiling out of the family photo;
Their smiles catch onto my skin, little smiling hooks.

I have let things slip, a thirty-year-old cargo boat
Stubbornly hanging on to my name and address.
They have swabbed me clear of my loving associations.
Scared and bare on the green plastic-pillowed trolley
I watched my teaset, my bureaus of linen, my books
Sink out of sight, and the water went over my head.
I am a nun now, I have never been so pure.

I didn't want any flowers, I only wanted
To lie with my hands turned up and be utterly empty.
How free it is, you have no idea how free——
The peacefulness is so big it dazes you,
And it asks nothing, a name tag, a few trinkets.
It is what the dead close on, finally; I imagine them
Shutting their mouths on it, like a Communion tablet.

The tulips are too red in the first place, they hurt me.
Even through the gift paper I could hear them breathe
Lightly, through their white swaddlings, like an awful baby.
Their redness talks to my wound, it corresponds.
They are subtle: they seem to float, though they weigh me down,
Upsetting me with their sudden tongues and their color,
A dozen red lead sinkers round my neck.

Nobody watched me before, now I am watched.
The tulips turn to me, and the window behind me
Where once a day the light slowly widens and slowly thins,
And I see myself, flat, ridiculous, a cut-paper shadow
Between the eye of the sun and the eyes of the tulips,
And I have no face, I have wanted to efface myself.
The vivid tulips eat my oxygen.

Before they came the air was calm enough,
Coming and going, breath by breath, without any fuss.
Then the tulips filled it up like a loud noise.
Now the air snags and eddies round them the way a river
Snags and eddies round a sunken rust-red engine.
They concentrate my attention, that was happy
Playing and resting without committing itself.

The walls, also, seem to be warming themselves.
The tulips should be behind bars like dangerous animals;
They are opening like the mouth of some great African cat,
And I am aware of my heart: it opens and closes
Its bowl of red blooms out of sheer love of me.
The water I taste is warm and salt, like the sea,
And comes from a country far away as health.

– Sylvia Plath
18 March 1961

William Matthews "We shall all be born again but we shall not all be saved"

William Matthews completed his undergraduate education at Yale University. He published eight collections of poetry, sat on the literature panel of the National Endowment for the Arts, and served as the President of the Poetry Society of America. Matthews' writing is known for its wise sayings, often constructed as metaphors, for example in this poem he becomes a loaf of bread as he is slid into the ambulance.

Here are some suggested questions to consider while reading and presenting Matthews' poem:

* What is the nature of the narrator's complex relationship with the hospital (both the objects and the people in the hospital)?
* The intern seems to be particularly polite, why can't he trust her? What has gone wrong in their relationship?
* What might he mean by "Another day I'd learn the obvious, / that it was me?"
* Do you think that existence in the hospital is a "balm of obedience and stupor" for some patients?
* Have you had patients who might have had some similar experiences to those of the narrator? Do you think any of your patients could relate to Matthews' poem?
* How might house officers approach and overcome some of the barriers to communication and understanding that Matthews raises in his poem?

WE SHALL ALL BE BORN AGAIN
BUT WE SHALL NOT ALL BE SAVED

"We're going," the paramedics said
(how I burned to be part of that *we*),
"to take you to the hospital."
It would be life as a direct object
for a while. Into the ambulance
they slid me like a loaf of bread.

There would be tests, I understood,
to see why my heart beat in triplets,
and I could see it myself, on TV,
an hour in the afternoon, like a soap
opera. Echo-cardiogram, they
called it. "Narcissus, is there someone

else?" I watched my eager heart
lash and batter for an hour, only
its normal violence, an intern assured
me, but she came back and back
abnormally to see me: "Can I listen
to your heart?" I couldn't trust her.

My green heart on TV looked violent.
This would be an inside job.
Who could break one of those but itself?
It's never been that we *have* bodies:
we *are* bodies. I had to trundle
a kind of aluminum coat-rack

along the hall just to pee, because
of the IV, and I had to eat essence
of junket, and nurses brought me pills
in little paper thimbles. This balm
of obedience and stupor, I thought
my docile study. I'd been too sick to take
my own side in a fight, but against whom?
Another day I'd learn the obvious,
that it was me, but that's another story.
In this one I'm untethered from my
machines, my mild, green-faced flock,

and can walk around weakly on my own,
can pack my bags and pills and go out
into Boston safe to die some other day.
"How will this change your life?"
My heart will push me along like a good
rhythm section. I plan to notice everything.

—*William Matthews*

Mona Van Duyn "In the hospital for tests"

Mona Van Duyn (pronounced "van dine") is a distiguished American poet who has won dozens of prizes and awards, including a National Book Award for *To See, To Take* (1971) and a Pulitzer Prize for *Near Changes* (1991).

Van Duyn uses colloquial language to find the extraordinary in the familiar. One critic noted that she comments "on painful confrontation after it has ceased, [and then] she surveys what can be salvaged from the wreakage. In the act of writing, the poet recalls experience and recreates it, giving shape and harmony to events without escaping into illusion; this kind of writing is an act of redemption that can make the worst aspects of life more endurable."

"In the hospital for tests" raises some interesting perspectives and questions. The following are possible questions for the discussion of her poem.

* How is the hospital and the narrator's body a jail?
* What is the narrator's relationship with the intern? With the other patient in her room? How do the relationships change over the course of the poem?
* Why did the poet decide to include the line that begins, "She was only fifteen...?"
* The second to last stanza is not as straight forward as the rest of the poem. What appears to be going on here? How does Van Duyn use language to convey this?
* Does the poem rise above its simple everyday descriptions? Does your patient rise above day-to-day life in the hospital? Do you?
* What issues in the poem are similar to issues concerning the care of your patient on the wards?

IN THE HOSPITAL FOR TESTS

My mother's friend cooked for the drunk-and-disorderlies,
and so, when I was ten, I peeked at a cell,
and that's what I'd swear this room came out of—the county jail.
But here in a sweat lies a strange collection of qualities,
with me inside it, or maybe only somewhere near it,
while all the nonsense of life turns serious again—
bowel movements, chickenpox, the date of one's first menstruation,
the number of pillows one sleeps on, postnasal drip—
"It has very high arches," I hear the resident note.
He has worked his way down over its ridges and jerks,
its strings and moistures, coursings, lumps and networks,
to the crinkled and slightly ticklish soles of its feet.
"Don't worry, if there's anything going on here," the interne says,
"we'll find it. I myself have lots of ideas."

Across the room, over a jungle of plants,
blooming, drooping, withering, withered and dead,
a real face watches, freckled and flat blue eyed.
Sometimes her husband visits, a man of plaid shirts
and apologetic smiles, and sometimes three red-head
little girls in stairsteps, too scared to talk out loud.

In twenty-four hours, the hefty nurse, all smiles,
carries out my urine on her hip like a jug of cider,
a happy harvest scene. My room-mate, later,
gets on a stretcher, clutching her stomach, and it wheels
her off down the halls for a catheter in her heart.
There's one chance in five hundred she'll die in the test. She'd like
to live for two more years for the children's sake.
Her husband waits in the room. He sweats. We both sweat.

She was only fifteen when they married, he says, but she told him
she was past eighteen and he didn't find out for years.
She's wheeled back, after a feverish two hours,
with black crochet on her arm. She was conscious all the time,
and could feel whatever it was, the little black box, go

The leukemia across the hall, the throat cancer a few doors down,
the leaky valve who has to sleep on eight pillows—
these sit on our beds and talk of the soggy noodles
they gave us for lunch, and the heat, and how long, how soon.
The room stinks of my urine and our greed.
To live, to live at all costs, that's what we want.
We never knew it before, but now we hunt
down the healthy nurses with our eyes. We gobble our food.
Intruders come from outside during visiting hours
and chatter about silly things, no longer our affairs.

"A little more blood, I'm on the trail." He'll go far,
my interne. My room-mate gets on the stretcher again;
she comes back almost dead, but they give her oxygen.
She whistles for breath, her face is swollen and sore
and dark. She spits up white rubber. The bronchoscope,
that's what it was this time, and more tests to come.
She wishes her husband had been here after this one.
They were going to do the other lung too, but they had to stop.

In the middle of the night her bed blazes white in the darkness.
Three red-headed daughters dangle from her lightcord.
The nurse holds a cup to her lips. It is absurd,
she is swallowing my poems. The air knots like a fist,
or a heart, the room presses in like a lung. It is empty
of every detail but her life. It is bright and deathly.

"You can go home this afternoon. You're all checked out."
My doctor is grinning over the obscene news.
My room-mate sits up and listens. "God only knows
what causes these things, but you've nothing to worry about."
In shame I pack my bags and make my call.
She reads a magazine while I wait for my husband.
She doesn't speak, she is no longer my friend.
We say goodbye to each other. I hope she does well.
In shame I walk past the staring eyes and their reproaches
all down the hall. I walk out on my high arches.

—Mona Van Duyn

Bibliographic guide to American poetry and medicine

Anthologies of poetry and medicine:

Jon Mukand, ed. Articulations: The Body and Illness in Poetry. University of Iowa Press. 1994.
This is a compilation of poems on medical themes by many poets. The poems are written, by the most part, by established authors, some of whom are also practicing physicians. These contemporary poems are recommended for their accessibility and diversity.

American poets who have written poetry that is relevant to medicine include:

William Carlos Williams. Williams was a pediatrician in Rutherford, New Jersey. He was also a poet who set out to create a specifically American poetics, based on rhythms and colorations of American speech, thought, and experience. Often drawing on his medical experiences in his poetry, Williams is the prototypical American physician-poet.

Sylvia Plath. Sylvia Plath struggled with mental illness throughout her life. She published several collections of poetry and an autobiographic book, The Bell Jar. Her work is intimately tied to her struggle with depression. She has also written poems that address suicide, insomnia, and life in the hospital, all of which are thematically relevant to clinical medicine.

Anne Sexton. Sexton began writing poetry at the suggestion of her therapist. Notable for its frankness and intimacy, Sexton's poetry often explores topics that are relevant to medicine including suicide, depression, insomnia, the hospital, and death and dying. Her collection of poetry is published by Houghton Mifflin Company.

Marilyn Hacker. Hacker is a contemporary American poet whose poetry often explores the nature of identity. After her experience with breast cancer, she wrote the provokative collection 'Cancer Winter' which can be found in her book Winter Numbers .

Beyond these well-known poets there are many other contemporary poets whose work is directly relevant to medicine Poets in this category include ***Rika Lesser, Audry Lord, Eve Sedgwick, Alice Jones,*** and ***Forest Hamer***

Poetry of AIDS:

Rafael Campo. Possibly because he is a practicing physician himself, Campo's poetry is probably the most accessible poetry of AIDS for medical professionals. He is a Cuban-American internist in Boston and has published two collections of poetry The Other Man Was Me and What the Body Told. He has also published a collection of essays entitled The Poetry of Healing. Much of his work, both poetry and prose, concerns issues of identity within medical, latino, and gay cultures.

Thom Gunn. As poet and teacher living in San Francisco, Gunn has written eloquently of the nature and devastation of AIDS. His most pertinent collection in this respect is The Man with Night Sweats. Gunn's well regarded stature within the American literary community should not deter an inexperienced reader from approaching his very accessible work.

Paul Monette. Monette is a modern gay poet who has written extensively on AIDS. His most well-known work on this topic is a very complex series of elegies to his lover who died of AIDS. These elegies are collected in Love Alone: 18 Elegies for Rog a more recent collection of his poetry is entitled West of Yesterday, East of Summer. I do not recommend Monette as your first introduction to the poetry of the AIDS era, but he is a rewarding and challenging poet to explore.

Other poets who have eloquently of AIDS include ***David Bergman, Heather McHugh,*** and ***Mark Doty***. Anthologies of AIDS poetry include Poets for Life (two volumes) edited by Michael Klein and Unending Dialogue: Voices from an AIDS poetry workshop edited by Rachel Hadas. Klein, in Poets for Life, collected previously published poetry as well as works written specifically for his collection. The collection Unending Dialogue consists of poems written for an AIDS-poetry workshop.

Poetry on rounds

anger

Table of Contents

Poetry on Rounds:
Anger

Pieter Cohen
Yale Medical School

How to approach your poem

I. Introduction

We will be spending 15 to 20 minutes of attending rounds discussing one poem in relation to a specific clinical situation on the wards. ***Don't panic*** — this discussion requires no previous knowledge, understanding, or comfort with poetry. Hopefully, poetry will provide a common ground to discuss issues relevant to clinical medicine that may not be easily discussed using the medical literature alone.

II. Choosing a poem

In this packet, you will find three or four poems, each with an introductory coversheet. You may choose one of the poems in this packet or bring in a different poem to discuss. You may select your poem for any reason, keeping your patient in mind. You might want to begin the discussion by explaining why you chose the poem. In addition, you might want to give the poem to other members of your team to read ahead of time.

III. Analyzing your poem

Reading, understanding, thinking and discussing poetry is in many ways completely different from the biomedical model we are accustomed to using in the hospital. On the wards, we use clinical knowledge to narrow down differential diagnoses to uncover the truth and find solutions to complex problems. In complex poetry, there are no correct answers and a single interpretation is neither necessarily right nor wrong. In the language of poetry multiple meanings may exist simultaneously. We learn to live with uncertainty and ambiguity. A corollary of this is that there may not be simple conclusions to be drawn. As our personal experiences change, our understanding of a poem may change.

As you begin to read and think about the poem you selected, remember that your presentation will draw more from the connections you find between your poem, your patient and your personal experiences than your literary expertise. In other words, it will not be necessary to analyze your poem as if you were a literature graduate student.

Let your mind wander freely when you are thinking about the poem. There is *not a right answer* when understanding poetry. For each poem there may be many themes and interpretations. Assume that each word, phrase and sentence has multiple meanings. If readers have different points of view, they may all be correct. There are some interpretations that might be more convincing than others, but the goal of the discussion will be to provide a comfortable environment to share different points of view. If the poem suggests something to you, it is worthy of discussion. Ezra Pound has described poetry as "language charged with meaning to the utmost possible degree." Therefore, don't hold back in your interpretations and associations.

Here are some pointers to keep in mind when considering your poem: 1) read your poem; 2) take a deep breath; 3) reread your poem and think about it; 4) do not get hung-up on parts of the poem you do not understand—you do not need to understand everything about the poem.

Aspects of the poem you may want to consider include: 1) the content; 2) the themes (there usually will be several); 3) the narrator's perspective; 5) what issues, concerns, and perspectives does the poem raise in the context of your clinical scenario; 6) your emotional response to the poem and your emotional response to your patient.

Although it is not necessary, if you are so inclined you may wish to address some of the literary aspects of your poem. You may want to assess the tone (attitude of the author toward his or her subject), and the complexity of the language (syntax, rhythm, word choice, meter, metaphors, analogies).

IV. Presenting your poem

The most important aspects of a successful presentation will be simply to have photocopied the poem for all members of the group, read the poem out loud at the onset, and provide an open and supportive environment for the discussion. The team might not know where to begin the discussion after you have read the poem aloud. Come prepared with some thoughts and comments. An introduction may be to simply begin by talking about what you liked, or disliked, in the poem and why you chose it.

An important part of the discussion will be connecting your poem back to your patient. Sometimes the clinical scenario will be strikingly similar in the poem and the connections will be obvious. However, most of the time the connections may not be very clear. In these cases, it might be easier to think of the poem as an analogy, metaphor, or allegory of your clinical situation. There are many other ways to connect the poem to the clinical situation: for example, you could consider the perspective in the poem and consider how that perspective may, or may not, be similar to your patient's. Another approach would be to consider the feelings, concerns and anxieties that reading this poem might evoke for the team with respect to this clinical situation, or how your patient might feel if he or she were to read the poem.

Above all, have fun with the experience. Remember that the style and format of the presentations are open to your own creativity and interests. Enjoy them!

Robert Watson is an American poet and professor of English at University of North Carolina at Chapel Hill. He has published six collections of poetry as well as many academic publications. A recent critic noted "to stabilize the discontinuous thoughts of a moment, to cast a mundane or monotonous reflection in a lyric of captivating rhythm, these are the gifts of Robert Watson's poetry."

* What might Watson mean by "These wretches made us invisible and well, / Pick pocketed our each groomed ill?"
* What has the pair "renounced" in the last line?
* What challenges does the narrator's perspective create for the physician?
* Are you caring for, or do you recall caring for, a patient who engenders similar feelings and frustrations? Do these reactions interfere with care? How might these emotions best be addressed?

AT THE DOCTOR'S

Everyone could tell they had given up,
Abandoned amenities of attire, diet, soap;
She lean, face mean with fear or pain;
He obese, socks unmated, belches at the magazine
In which he looks and does not turn a page.
She would cry off and on.
They are themselves, nothing else, too far gone
To soothe our minds with any likeness
To familiar bird, beast, or fish.

An outrage:

They strung a spell over the doctor's office.
These wretches made us invisible and well,
Pick pocketed our each groomed ill.
They were so cruelly themselves, foreign and other.
Untended, their children bang and rain
Up and down the corridor like a hurricane.
They ruled the waiting room, this crude, poor pair
And they had renounced all that to us is dear.

—*Robert Watson*

William Carlos Williams "The Last Words of My English Grandmother"

William Carlos Williams (1883-1963) was America's foremost poet-physician. As a physician Williams cared for families in his hometown in northern New Jersey. As a poet Williams spoke for Americans at large. He has been called "the first American classic...his poetic line is organically welded to American speech like muscle to bone."[1] His poetry slowly gained the recognition and respect of American critics and he won the National Book Award during his lifetime and, posthumously, the Pulitzer Prize. As John Stone has written, "Williams changed the face of American poetry with his emphasis on everyday life and speech and his insistence on 'no ideas but in things': an exhortation to capture within poetry the physical things of this world."[2]

While reading and presenting Williams' poem you might want to consider the following questions:

* What might the elms represent? Why did Williams choose elms?
* What do you think about the grandmother juxtaposing her complaint that "they're starving me" with "I'm all right I won't go / to the hospital"?
* What would be the best approach to working up this patient if she arrived on your service? What types of feeling might she engender among the housestaff?
* Does your patient create some of the same feelings and frustrations?
* What might be some approaches to deal with the 'English grandmother' or your patient on the wards?

[1] Thirwall, John "Ten years of a new rhythm" in Williams, William Carlos Pictures from Brueghel and other poems. New Directions. New York. 1962.

[2] Reynolds, Richard, ed. and Stone, John, ed. On doctoring: stories, poems, essays. Simon & Schuster. New York. 1991.

THE LAST WORDS OF MY ENGLISH GRANDMOTHER

There were some dirty plates
and a glass of milk
beside her on a small table
near the rank, disheveled bed—

Wrinkled and nearly blind
she lay and snored
rousing with anger in her tones
to cry for food,

Gimme something to eat—
They're starving me—
I'm all right I won't go
to the hospital. No, no, no

Give me something to eat
Let me take you
to the hospital, I said
and after you are well

you can do as you please.
She smiled, Yes
you do what you please first
then I can do what I please—

Oh, oh, oh! she cried
as the ambulance men lifted
her to the stretcher—
Is this what you call

making me comfortable?
By now her mind was clear—
Oh you think you're smart
you young people,

she said, but I'll tell you
you don't know anything.
Then we started.
On the way

we passed a long row
of elms. She looked at them
awhile out of
the ambulance window and said,

What are all those
fuzzy-looking things out there?"
Trees? Well, I'm tired
of them and rolled her head away.

- William Carlos Williams

Illness and poetry were always intertwined in Anne Sexton's life and work. Sexton's psychiatrist first suggested she use poetry as therapy. What began as therapeutic poetry would later propel Sexton, who never graduated from college, to be elected a Fellow of the Royal Society of Literature in Great Britain, to win a Pulitzer Prize in poetry for *Live or Die* (1967), and to become a professor of creative writing at Boston University. However, her psychiatric illnesses continued to haunt her throughout her literary career.

Sexton often writes openly about her personal experiences in her poetry. She had attempted suicide many times in her life before the attempt in 1974 that took her life. Sexton's friend and fellow poet Maxine Kumin has written,

> "I am convinced that poetry kept Anne alive for the eighteen years of her creative endeavors. When everything else soured; when a succession of therapists deserted her for whatever good, poor, or personal reasons; when intimates lost interest or could not fulfill all the roles they were asked to play; when a series of catastrophes and physical illnesses assaulted her, the making of poems remained her one constant."[1]

Here are some questions to keep in mind when discussing "The doctor of the heart:"

* Even though an EKG might well be one of the most benign tests performed in the hospital, how does Sexton describe the test?
* What is Sexton's critique of the medical profession?
* What emotions might Sexton's attitudes engender among the house staff? What might be a useful approach to her fictitious patient?
* Are the narrator's sentiments similar to your patient's?
* How do patients' anger and disgust with the medical profession influence their care? How can physicians deal with patients' angry emotions? How can they deal with their own reactions to their patients' emotions?

[1] Kumin, Maxine. "How it was" in Anne Sexton: The Complete Poems. Houghton Mifflin Co. Boston. 1981. p.xxiii.

THE DOCTOR OF THE HEART

Take away your knowledge, Doktor.
It doesn't butter me up.

You say my heart is *sick unto.*
You ought to have more respect!

You with the goo on the suction cup.
You with your wires and electrodes

fastened at my ankle and wrist,
sucking up the biological breast.

You with your zigzag machine
playing like the stock market up and down.

Give me the Phi Beta key you always twirl
and I will make a gold crown for my molar.

I will take a slug if you please
and make myself a perfectly good appendix.

Give me a fingernail for an eyeglass.
The world was milky all along.

I will take an iron and press out
my slipped disk until it is flat.

But take away my mother's carcinoma
for I have only one cup of fetus tears.

Take away my father's cerebral hemorrhage
for I have only a jigger of blood in my hand.

Take away my sister's broken neck
for I have only my schoolroom ruler for a cure.

Is there such a device for my heart?
I have only a gimmick called magic fingers.

Let me dilate like a bad debt.
Here is a sponge. I can squeeze it myself.

O heart, tobacco red heart,
beat like a rock guitar.

I am at the ship's prow.
I am no longer the suicide

with her raft and paddle.
Herr Doktor! I'll no longer die

to spite you, you wallowing
seasick grounded man.

– Anne Sexton

Anthologies of poetry and medicine:

Jon Mukand, ed. Articulations: The Body and Illness in Poetry. University of Iowa Press. 1994.
This is a compilation of poems on medical themes by many poets. The poems are written, by the most part, by established authors, some of whom are also practicing physicians. These contemporary poems are recommended for their accessibility and diversity.

American poets who have written poetry that is relevant to medicine include:

William Carlos Williams. Williams was a pediatrician in Rutherford, New Jersey. He was also a poet who set out to create a specifically American poetics, based on rhythms and colorations of American speech, thought, and experience. Often drawing on his medical experiences in his poetry, Williams is the prototypical American physician-poet.

Sylvia Plath. Sylvia Plath struggled with mental illness throughout her life. She published several collections of poetry and an autobiographic book, The Bell Jar. Her work is intimately tied to her struggle with depression. She has also written poems that address suicide, insomnia, and life in the hospital, all of which are thematically relevant to clinical medicine.

Anne Sexton. Sexton began writing poetry at the suggestion of her therapist. Notable for its frankness and intimacy, Sexton's poetry often explores topics that are relevant to medicine including suicide, depression, insomnia, the hospital, and death and dying. Her collection of poetry is published by Houghton Mifflin Company.

Marilyn Hacker. Hacker is a contemporary American poet whose poetry often explores the nature of identity. After her experience with breast cancer, she wrote the provokative collection 'Cancer Winter' which can be found in her book Winter Numbers .

Beyond these well-known poets there are many other contemporary poets whose work is directly relevant to medicine. Poets in this category include ***Rika Lesser, Audry Lord, Eve Sedgwick, Alice Jones,*** and ***Forest Hamer***.

Poetry of AIDS:

Rafael Campo. Possibly because he is a practicing physician himself, Campo's poetry is probably the most accessible poetry of AIDS for medical professionals. He is a Cuban-American internist in Boston and has published two collections of poetry The Other Man Was Me and What the Body Told. He has also published a collection of essays entitled The Poetry of Healing. Much of his work, both poetry and prose, concerns issues of identity within medical, latino, and gay cultures.

Thom Gunn. As poet and teacher living in San Francisco, Gunn has written eloquently of the nature and devastation of AIDS. His most pertinent collection in this respect is The Man with Night Sweats. Gunn's well regarded stature within the American literary community should not deter an inexperienced reader from approaching his very accessible work.

Paul Monette. Monette is a modern gay poet who has written extensively on AIDS. His most well-known work on this topic is a very complex series of elegies to his lover who died of AIDS. These elegies are collected in Love Alone: 18 Elegies for Rog a more recent collection of his poetry is entitled West of Yesterday, East of Summer. I do not recommend Monette as your first introduction to the poetry of the AIDS era, but he is a rewarding and challenging poet to explore.

Other poets who have eloquently of AIDS include ***David Bergman, Heather McHugh,*** and ***Mark Doty***. Anthologies of AIDS poetry include Poets for Life (two volumes) edited by Michael Klein and Unending Dialogue: Voices from an AIDS poetry workshop edited by Rachel Hadas. Klein, in Poets for Life, collected previously published poetry as well as works written specifically for his collection. The collection Unending Dialogue consists of poems written for an AIDS-poetry workshop.

HARVEY CUSHING / JOHN HAY WHITNEY
MEDICAL LIBRARY

MANUSCRIPT THESES

Unpublished theses submitted for the Master's and Doctor's degrees and deposited in the Medical Library are to be used only with due regard to the rights of the authors. Bibliographical references may be noted, but passages must not be copied without permission of the authors, and without proper credit being given in subsequent written or published work.

This thesis by has been used by the following persons, whose signatures attest their acceptance of the above restrictions.

NAME AND ADDRESS DATE